

Monday, July 13, 2009

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, et al. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, and 485

[CMS-1413-P]

RIN 0938-AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would address proposed changes to Medicare Part B payment policy. We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This proposed rule discusses: Refinements to resource-based work, practice expense and malpractice relative value units (RVUs); geographic practice cost indices (GPCIs); telehealth services; several coding issues; physician fee schedule update for CY 2010; payment for covered part B outpatient drugs and biologicals; the competitive acquisition program (CAP); payment for renal dialysis services; the chiropractic services demonstration; comprehensive outpatient rehabilitation facilities; physician self-referral; the ambulance fee schedule; the clinical laboratory fee schedule; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and certain provisions of the Medicare Improvements for Patients and Providers Act of 2008. (See the Table of contents for a listing of the specific issues.)

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on Monday, August 31, 2009

ADDRESSES: In commenting, please refer to file code CMS-1413-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

- 1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions under the "More Search Options" tab.
- 2. By regular mail. You may mail written comments to the following

address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1413-P, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- 3. By express or overnight mail. You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1413-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.
- 4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:
- a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD— Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT:

- Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.
- Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices.
- Esther Markowitz, (410) 786–4595, for issues related to telehealth services.
- Ken Marsalek, (410) 786–4502, for issues related to the physician practice information survey and the multiple procedure payment reduction.

- Cathleen Scally, (410) 786–5714, for issues related to the initial preventive physical examination or consultation services.
- Regina Walker-Wren, (410) 786–9160, for issues related to the phasing out of the outpatient mental health treatment limitation.
- Diane Stern, (410) 786–1133, for issues related to the physician quality reporting initiative and incentives for e-prescribing.

Lisa Grabert, (410) 786–6827, for issues related to the Physician Resource Use Feedback Program.

Colleen Bruce, (410) 786–5529, for issues related to value-based purchasing.

Sandra Bastinelli, (410) 786–3630, for issues related to the implementation of accreditation standards.

Jim Menas, (410) 786–4507, for issues related to teaching anesthesia services.

Sarah McClain, (410) 786–2994, for issues related to the coverage of cardiac rehabilitation services.

Dorothy Shannon, (410) 786–3396, for issues related to payment for cardiac rehabilitation services.

Roya Lofti, (410) 786–4072, for issues related to the coverage of pulmonary rehabilitation.

Jamie Hermansen, (410) 786–2064, for issues related to kidney disease patient education programs.

Terri Harris, (410) 786–6830 for issues related to payment for kidney disease patient education.

Henry Richter, (410) 786–4562, or Lisa Hubbard, (410) 786–5472, for issues related to renal dialysis provisions and payments for end-stage renal disease facilities.

Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Pauline Lapin, (410) 786–6883, for issues related to the chiropractic services demonstration budget neutrality issue.

Monique Howard, (410) 786–3869, for issues related to CORF conditions of coverage.

Roechel Kujawa, (410) 786–9111, for issues related to ambulance services.

Anne Tayloe Hauswald, (410) 786–4546, for clinical laboratory issues.

Troy Barsky, (410) 786–8873, or Roy Albert, (410) 786–1872, for issues related to physician self-referral.

Michelle Peterman, (410) 786–2591, or Iffat Fatima, (410) 786–6709 for issues related to the grandfathering provisions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Acquisition Program.

Ralph Goldberg, (410) 786-4870, or Heidi Edmunds, (410) 786-1781, for issues related to the damages process caused by the termination of contracts awarded in 2008 under the DMEPOS

Competitive Bidding program. Diane Milstead, (410) 786–3355, or Gaysha Brooks, (410) 786-9649, for all other issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://

www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the Code of Federal Regulations (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section V. of this proposed rule.

- I. Background
 - A. Development of the Relative Value System
 - 1. Work RVUs
 - 2. Practice Expense Relative Value Units (PE RVUs)
 - 3. Resource-Based Malpractice RVUs
 - 4. Refinements to the RVUs
 - 5. Adjustments to RVUs Are Budget Neutral
 - B. Components of the Fee Schedule Payment Amounts
- C. Most Recent Changes to Fee Schedule II. Provisions of the Proposed Regulation
- A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
- 1. Current Methodology

- a. Data Sources for Calculating Practice Expense
- b. Allocation of PE to Services
- c. Facility and Nonfacility Costs
- d. Services With Technical Components (TCs) and Professional Components
- e. Transition Period
- f. PE RVU Methodology
- 2. PE Proposals for CY 2010
- a. SMS and Supplemental Survey Background
- b. Physician Practice Information Survey (PPIS)
- c. Equipment Utilization Rate
- d. Miscellaneous PE Issues
- e. AMA RUC PE Recommendations for Direct PE Inputs
- B. Geographic Practice Cost Indices (GPCIs): Locality Discussion
- 1. Update—Expiration of 1.0 Work GPCI Floor
- 2. Payment Localities
- C. Malpractice RVUs
- 1. Background
- 2. Proposed Methodology for the Revision of Resource-Based Malpractice RVUs
- D. Medicare Telehealth Services
- 1. Requests for Adding Services to the List of Medicare Telehealth Services
- 2. Submitted Requests for Addition to the List of Telehealth Services
- E. Specific Coding Issues Related to Physician Fee Schedule
- 1. Canalith Repositioning
- 2. Payment for an Initial Preventive Physical Examination (IPPE)
- 3. Audiology Codes: Policy Clarification of Existing CPT Codes
- 4. Consultation Services
- F. Potentially Misvalued Codes Under the Physician Fee Schedule
- 1. Valuing Services Under the Physician Fee Schedule
- 2. High Cost Supplies
- 3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Services
- 4. AMA RUC Review of Potentially Misvalued Services
- a. Site of Service Anomalies
- b. "23-Hour" Stay
- 5. Establishing Appropriate Relative Values for Physician Fee Schedule Services
- G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
- 1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services
- 2. Section 131(b): Physician Payment, Efficiency, and Quality Improvements-Physician Quality Reporting Initiative
- 3. Section 131(c): Physician Resource Use Measurement and Reporting Program
- 4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners
- 5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescibing Incentive Program
- 6. Section 135: Implementation of Accreditation Standards for Suppliers

- Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services
- 7. Section 139: Improvements for Medicare Anesthesia Teaching Programs
- 8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services
- 9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabitation Services
- 10. Section 152(b): Coverage of Kidney Disease Patient Education Services
- 11. Section 153: Renal Dialysis Provisions
- 12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen
- H. Part B Drug Payment
- 1. Average Sales Price (ASP) Issues
- 2. Competitive Acquisition Program (CAP) Issues
- I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities
- J. Discussion of Chiropractic Services Demonstration
- Background
- 2. Analysis of Demonstration
- 3. Payment Adjustment
- K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues
- L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (414.610)
- M. Clinical Laboratory Fee Schedule: Signature on Requisition
- N. Physician Self-Referral
- 1. General Background
- 2. Physician Stand in the Shoes
- O. Durable Medical Equipment-Related
- 1. Damages to Suppliers Awarded a Contract Under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program
- 2. Notification to Beneficiaries for Suppliers Regarding Grandfathering
- P. Physician Fee Schedule Update for CY 2010
- III. Collection of Information Requirements IV. Response to Comments
- V. Regulatory Impact Analysis Regulation Text
- Addendum A—Explanation and Use of Addendum B
- Addendum B—Proposed Relative Value Units and Related Information Used in Determining Medicare Payments for CY

Addendum C—[Reserved] Addendum D—Proposed 2010 Geographic Adjustment Factors (GAFs)

Addendum E—Proposed 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Addendum F—Proposed CY 2010 ESRD Wage Index for Urban Areas Based on CBŠA Labor Market Areas

Addendum G—Propsoed CY 2010 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation

ACC American College of Cardiology ACGME Accreditation Council on Graduate Medical Education

ACR American College of Radiology AFROC Association of Freestanding Radiation Oncology Centers AHA American Heart Association

AHRQ [HHS'] Agency for Healthcare Research and Quality

AIDS Acquired immune deficiency syndrome

American Medical Association AMA AMP Average manufacturer price

American Osteopathic Association AOAAPA American Psychological Association

APTA American Physical Therapy Association

Ambulatory surgical center

ASP Average sales price ASRT American Society of Radiologic Technologists

ASTRO American Society for Therapeutic Radiology and Oncology

ATA American Telemedicine Association

AWP Average wholesale price

BBA Balanced Budget Act of 1997 (Pub. L.

BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)

BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106-554)

BLS Bureau of Labor Statistics BN Budget neutrality

CABG Coronary artery bypass graft CAD Coronary artery disease

CAH Critical access hospital

CAHEA Committee on Allied Health Education and Accreditation

Competitive acquisition program CBSA Core-Based Statistical Area

CCHIT Certification Commission for Healthcare Information Technology

CEAMA Council on Education of the American Medical Association

CF Conversion factor

CfC Conditions for Coverage

CFR Code of Federal Regulations

CKD Chronic kidney disease

CLFS Clinical laboratory fee schedule

California Medical Association

CMHC Community mental health center

CMP Civil money penalty

CMS Centers for Medicare & Medicaid Services

Clinical nurse specialist

CoP Condition of participation COPD Chronic obstructive pulmonary disease

CORF Comprehensive Outpatient Rehabilitation Facility

COS Cost of service

Clinical Practice Expert Panel CPI Consumer Price Index

CPI-U Consumer price index for urban

CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)

Cardiac rehabilitation

CRNA Certified registered nurse anesthetist

CRP Canalith repositioning

CRT Certified respiratory therapist

Clinical social worker

CY Calendar year

DHS Designated health services

Durable medical equipment DMEPOS Durable medical equipment,

prosthetics, orthotics, and supplies

DOQ Doctor's Office Quality DRA Deficit Reduction Act of 2005 (Pub. L.

109-171)

DSMT Diabetes self-management training E/M Evaluation and management

EDIElectronic data interchange

Electroencephalogram EEG Electronic health record EHR

EKG Electrocardiogram

Electromyogram EMG

EMTALA Emergency Medical Treatment and Active Labor Act

EOG Electro-oculogram

EPO Erythropoietin

ESRD End-stage renal disease

Facsimile FAX

Food and Drug Administration (HHS) FDA

FEV Forced expiratory volume

FFS Fee-for-service

FR Federal Register

FVC Forced expiratory vital capacity (liters)

GAF Geographic adjustment factor GAO General Accountability Office

Generating Medicare [Physician **GEM**

Quality Performance Measurement Results] Glomerular filtration rate

GPO Group purchasing organization

GPCI Geographic practice cost index

HAC

Hospital-acquired conditions

HBAI Health and behavior assessment and intervention

HCPAC Health Care Professional Advisory Committee

HCPCS Healthcare Common Procedure Coding System

HCRIS Healthcare Cost Report Information System

HDRT High dose radiation therapy HH PPS Home Health Prospective Payment

System HHA Home health agency

Home health resource group HHS [Department of] Health and Human

Services HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-

HIT Health information technology

HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)

HITSP Healthcare Information Technology Standards Panel

HIV Human immunodeficiency virus

HOPD Hospital outpatient department

HPSA Health Professional Shortage Area HRSA Health Resources Services

Administration (HHS)

ICD International Classification of Diseases IACS Individuals Access to CMS Systems

ICF Intermediate care facilities

ICR Intensive cardiac rehabilitation Information collection requirement

IDTF Independent diagnostic testing facility IFC Interim final rule with comment period

IMRT Intensity-Modulated Radiation Therapy

IPPE Initial preventive physical examination

IPPS Inpatient prospective payment system

Internal Revenue Service

ISO Insurance services office

IVD Ischemic Vascular Disease

IVIG Intravenous immune globulin

IWPUT Intra-service work per unit of time JRCERT Joint Review Committee on

Education in Radiologic Technology Joint underwriting association

Kidney disease education

MA Medicare Advantage

MA-PD Medicare Advantage-Prescription **Drug Plans**

MCMP Medicare Care Management Performance

MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))

MedPAC Medicare Payment Advisory Commission

MEI Medicare Economic Index

MIEA-TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109-432)

MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-

MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173)

MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173)

MNT Medical nutrition therapy

MP Malpractice

MPPR Multiple procedure payment reduction

MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)

MRA Magnetic resonance angiography

MRI Magnetic resonance imaging MS-DRG Medicare Severity-Diagnosis related group

MSA Metropolitan statistical area

NCD National Coverage Determination

National Claims History NCH

NCPDP National Council for Prescription Drug Programs

NCQDIS National Coalition of Quality Diagnostic Imaging Services

NDC National drug code

NF Nursing facility

NISTA National Institute of Standards and Technology Act

NP Nurse practitioner

NPDB National Practitioner Data Bank

NPI National Provider Identifier

NPP Nonphysician practitioner NPPES National Plan and Provider Enumeration System NOF National Quality Forum NRC Nuclear Regulatory Commission NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104– NUBC National Uniform Billing Committee OACT [CMS'] Office of the Actuary OBRA Omnibus Budget Reconciliation Act ODF Open door forum OIG Office of Inspector General Office of Management and Budget ONC [HHS'] Office of the National Coordinator OPPS Outpatient prospective payment OSA Obstructive Sleep Apnea OSCAR Online Survey and Certification and Reporting P4P Pay for performance PA Physician assistant PBM Pharmacy benefit manager PC Professional component PCF Patient compensation fund PCI Percutaneous coronary intervention PDE Prescription drug event PDP Prescription drug plan PE Practice expense PE/HR Practice expense per hour PEAC Practice Expense Advisory Committee PECOS Provider Enrollment, Chain, and Ownership System PERC Practice Expense Review Committee PFS Physician Fee Schedule PGP [Medicare] Physician Group Practice PHP Partial hospitalization program PIM [Medicare] Program Integrity Manual PLI Professional liability insurance POA Present on admission POC Plan of care PPI Producer price index PPIS Physician Practice Information Survey PPS Prospective payment system PPTA Plasma Protein Therapeutics Association PQRI Physician Quality Reporting Initiative PRA Paperwork Reduction Act **PSA** Physician scarcity areas Polysomnography PT Physical therapy PTCA Percutaneous transluminal coronary angioplasty RA Radiology assistant Recovery Act American Recovery and Reinvestment Act (Pub. L. 111–5) ResDAC Research Data Assistance Center RFA Regulatory Flexibility Act Regulatory impact analysis RN Registered nurse RNAC Reasonable net acquisition cost RPA Radiology practitioner assistant RRT Registered respiratory therapist RUC [AMA's Specialty Society] Relative (Value) Update Committee RVU Relative value unit SBA Small Business Administration SGR Sustainable growth rate SLP Speech-language pathology SMS [AMA's] Socioeconomic Monitoring System Skilled nursing facility SNF SOR System of record

SRS

Stereotactic radiosurgery

TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of
2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical
Center
USDE United States Department of
Education
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians" Services." The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on our review of recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: The Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate

specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the Federal Register (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the Calendar Year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less

often than every 5 years. The first 5-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second 5-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third 5-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (Note: Additional codes relating to the third 5-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new methodology for determining resourcebased PE RVUs and are transitioning this over a 4-year period. (Note: In section II.A.2. of this proposed rule, we are proposing to use new survey data under the PE methodology.)

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263). (Note: In section II.C. of this proposed rule, we are proposing to update the malpractice RVUs with the use of new data.)

5. Adjustments to RVUs are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than \$20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than \$20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than \$20 million.

As explained in the CY 2009 PFS final rule with comment period (73 FR 69730), as required by section 133(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), the separate budget neutrality (BN) adjustor resulting from the third 5-Year Review of physician work RVUs is being applied to the CF beginning with CY 2009 rather than the work RVUs.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physicians' service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice expense in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which is calculated by CMS' Office of the Actuary (OACT).

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

 $\begin{aligned} \text{Payment} &= \left[(\text{RVU work} \times \text{GPCI work}) + \\ & (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU} \\ & \text{malpractice} \times \text{GPCI malpractice}) \right] \times \\ & \text{CF} \end{aligned}$

C. Most Recent Changes to the Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) implemented changes to the PFS and other Medicare Part B payment policies finalized the CY 2008 interim RVUs and implemented interim RVUs for new and revised codes for CY 2009 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

The CY 2009 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute, and based on section 131 of the MIPPA, the CY 2009 PFS final rule with comment period also announced that the PFS update is 1.1 percent for CY 2009, the initial estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is \$36.0666.

II. Provisions of the Proposed Regulation

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act.

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

The initial implementation of resource-based PE RVUs was delayed from January 1, 1998, until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required that the new payment methodology be phased in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation of the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of the BBA required that, in developing the resource-based PE RVUs, the Secretary must—

• Use, to the maximum extent possible, generally-accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization.

 Develop a refinement method to be used during the transition.

• Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual

In CY 1999, we began the 4-year transition to resource-based PE RVUs utilizing a "top-down" methodology whereby we allocated aggregate specialty-specific practice costs to individual procedures. The specialtyspecific PEs were derived from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS). In addition, under section 212 of the BBRA, we established a process extending through March 2005 to supplement the SMS data with data submitted by a specialty. The aggregate PEs for a given specialty were then allocated to the services furnished by that specialty on the basis of the direct input data (that is, the staff time, equipment, and supplies) and work RVUs assigned to each CPT code.

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the "top-down" approach to calculate the direct PE

RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a "bottom-up" approach to calculate the direct costs. Under the "bottom up" approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed explanation of the PE methodology, see the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

Note: In section II.A.1 of this proposed rule, we discuss the current methodology used for calculating PE. In section II.A.2. of this proposed rule, which contains PE proposals for CY 2010, we are proposing to use data from the AMA Physician Practice Information Survey (PPIS) in place of the AMA's SMS survey data and supplemental survey data that is currently used in the PE methodology.

1. Current Methodology

a. Data Sources for Calculating Practice Expense

The AMA's SMS survey data and supplemental survey data from the specialties of cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, gastroenterology, radiology, independent diagnostic testing facilities (IDTFs), radiation oncology, and urology are used to develop the PE per hour (PE/ HR) for each specialty. For those specialties for which we do not have PE/HR, the appropriate PE/HR is obtained from a crosswalk to a similar specialty.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (See the CY 2002 PFS final rule with comment period (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 2005. The SMS data provide the following six categories of PE costs:

 Clinical payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician clinical personnel.

• Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial, or clerical activities.

• Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.

 Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.

• Medical equipment expenses, which include depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients.

• All other expenses, which include expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not previously mentioned in this section.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, those entities and organizations representing the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. In the CY 2002 PFS final rule (66 FR 55246), the deadline was extended through August 1, 2003. To ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005 in the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2004 final rule with comment period (68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule with comment period).

The direct cost data for individual services were originally developed by the Clinical Practice Expert Panels (CPEP). The CPEP data include the supplies, equipment, and staff times specific to each procedure. The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (for example, RNs) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting.

The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment. The CPEP data has been regularly updated by various RUC committees on PE.

b. Allocation of PE to Services

The aggregate level specialty-specific PEs are derived from the AMA's SMS survey and supplementary survey data. To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) Direct costs. The direct costs are determined by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide the service. The costs of these resources are calculated from the refined direct PE inputs in our PE database. These direct inputs are then scaled to the current aggregate pool of direct PE RVUs. The aggregate pool of direct PE RVUs can be derived using the following formula: (PE RVUs × physician CF) × (average direct percentage from SMS /(Supplemental PE/HR data)).

(ii) Indirect costs. The SMS and supplementary survey data are the source for the specialty-specific aggregate indirect costs used in our PE calculations. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. For calculation of the 2010 PE RVUs, we use the 2008 procedure-specific utilization data crosswalked to 2010 services. To arrive at the indirect PE costs—

• We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.

 We use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent

laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (Note: For radiation oncology, the data represent the combined survey data from the American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.

• When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility and Nonfacility Costs

Procedures that can be furnished in a physician's office, as well as in a hospital or facility setting have two PE RVUs: Facility and nonfacility. The nonfacility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs). The methodology for calculating PE RVUs is the same for both facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the PFS), the PE RVUs are generally lower for services provided in the facility setting.

d. Services With Technical Components (TCs) and Professional Components (PCs)

Diagnostic services are generally comprised of two components: A professional component (PC) and a technical component (TC), both of which may be performed independently or by different providers. When services have TCs, PCs, and global components that can be billed separately, the payment for the global component equals the sum of the payment for the TC and PC. This is a result of using a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global components, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global components, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global under the bottom-up methodology.)

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), the change to the PE methodology was implemented over a 4-year period. In CY 2010, the transition period is concluded and PE RVUs will be calculated based entirely on the current methodology.

f. PE RVU Methodology

The following is a description of the PE RVU methodology.

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/nonfacility place of service level, and the specialty-specific survey PE per physician hour data.

(ii) Calculate the Direct Cost PE RVUs Sum the Costs of Each Direct Input

Step 1: Sum the direct costs of the inputs for each service. The direct costs consist of the costs of the direct inputs for clinical labor, medical supplies, and medical equipment. The clinical labor cost is the sum of the cost of all the staff types associated with the service; it is the product of the time for each staff type and the wage rate for that staff type. The medical supplies cost is the sum of the supplies associated with the service; it is the product of the quantity of each supply and the cost of the supply. The medical equipment cost is the sum of the cost of the equipment associated with the service; it is the product of the number of minutes each piece of equipment is used in the

service and the equipment cost per minute. The equipment cost per minute is calculated as described at the end of this section.

Apply a BN Adjustment to the Direct Inputs

Step 2: Calculate the current aggregate pool of direct PE costs. To do this, multiply the current aggregate pool of total direct and indirect PE costs (that is, the current aggregate PE RVUs multiplied by the CF) by the average direct PE percentage from the SMS and supplementary specialty survey data.

Step 3: Calculate the aggregate pool of direct costs. To do this, for all PFS services, sum the product of the direct costs for each service from Step 1 and the utilization data for that service.

Step 4: Using the results of Step 2 and Step 3 calculate a direct PE BN adjustment so that the aggregate direct cost pool does not exceed the current aggregate direct cost pool and apply it to the direct costs from Step 1 for each service.

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the Medicare PFS CF.

(iii) Create the indirect PE RVUs.

Create indirect allocators.

Step 6: Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentages for each physician

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, we are calculating the direct and indirect percentages across the global components, PCs, and TCs. That is, the direct and indirect percentages for a given service (for example, echocardiogram) do not vary by the PC, TC and global component.

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: The direct PE RVU, the clinical PE RVU, and the work RVU

For most services the indirect allocator is: *indirect percentage* * (direct PE RVU/direct percentage) + work RVU.

There are two situations where this formula is modified:

• If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: Indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.

• If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *Indirect percentage* * (direct PE RVU/direct percentage) + clinical PE RVU.

Note: For global services, the indirect allocator is based on both the work RVU and the clinical labor PE RVU. We do this to recognize that, for the professional service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVU and the clinical labor PE RVU. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.

For presentation purposes in the examples in the Table 1, the formulas were divided into two parts for each service. The first part does not vary by service and is the indirect percentage * (direct PE RVU/direct percentage). The second part is either the work RVU, clinical PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVU exceeds the work RVU (as described earlier in this step.)

Apply a BN Adjustment to the Indirect Allocators

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. This is similar to the Step 2 calculation for the direct PE RVUs.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. This is similar to the Step 3 calculation for the direct PE RVUs.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8. This is similar to the Step 4 calculation for the direct PE RVUs.

Calculate the Indirect Practice Cost Index

Step 12: Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time

for the service, and the specialty's utilization for the service.

Step 14: Using the results of Step 12 and Step 13, calculate the specialty-specific indirect PE scaling factors as under the current methodology.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service.

Note: For services with TCs and PCs, we calculate the indirect practice cost index across the global components, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC and global component.

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVU.

(iv) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

Step 19: Calculate and apply the final PE BN adjustment by comparing the results of Step 18 to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (See "Specialties excluded from ratesetting calculation" below in this section.)

(v) Setup File Information

• Specialties excluded from ratesetting calculation: For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties are included for the purposes of calculating the BN adjustment.

 Crosswalk certain low volume physician specialties: Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.

• Physical therapy utilization: Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.

• Identify professional and technical services not identified under the usual

TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.

• Payment modifiers: Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any

service that contains the assistant at surgery modifier.

• Work RVUs: The setup file contains the work RVUs from this proposed rule.

(vi) Equipment cost per minute

The equipment cost per minute is calculated as:

(1/(minutes per year * usage)) * price * ((interest rate/(1 – (1/((1 + interest rate) ** life of equipment)))) + maintenance)

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); 150,000 minutes.

usage = equipment utilization assumption;
 0.9 for certain equipment (see section
 II.A.2. of this proposed rule) and 0.5. for others.

 $interest\ rate = 0.11.$

life of equipment = useful life of the
 particular piece of equipment.
maintenance = factor for maintenance; 0.05.

Note: To illustrate the PE calculation, in Table 1 we have used the conversion factor (CF) of \$36.0666 which is the CF effective January 1, 2009 as published in CY 2009 PFS final rule with comment period.

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TABLE 1: Calculation of PE RVUs under Methodology for Selected Codes

		Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single Facility	71020 Chest x-ray Nonfacility	71020TC Chest x-ray Nonfacility	7102026 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
Ξ	Labor cost (Lab)	Step 1	AMA		\$13.32	\$77.52	\$5.74	\$5.74	-\$	\$6.12	\$6.12	···-\$
3	Supply cost (Sup)	Step 1	AMA		\$2.98	\$7.34	\$3.39	\$3.39	S	\$1.19	\$1.19	\$
ව	Equipment cost (Eqp)	Step 1	AMA		\$0.19	\$0.65	\$8.17	\$8.17	\$	\$0.12	\$0.12	S
<u></u>	-	Step 1		=(1)+(2)+(3)	\$16.50	\$85.51	\$17.31	\$17.31	s	\$7.43	\$7.43	-\s
9	Direct adjustment (Dir Adj)	Steps 2-4	See footnote*		0.508	0.508	0.508	0.508	0.508	0.508	0.508	0.508
9	Adjusted labor	Steps 2-4	=Lab*Dir Adj	=(1)*(5)	\$6.76	\$39.35	\$2.91	\$2.91	\$	\$3.11	\$3.11	-\$
3	Adjusted supplies	Steps 2-4	=Sup*Dir Adj	=(2)*(5)	\$1.51	\$3.73	\$1.72	\$1.72	S	\$0.61	\$0.61	s
8	Adjusted equipment	Steps 2-4	=Eqp*Dir Adj	=(3)*(5)	\$0.10	\$0.33	\$4.15	\$4.15	7	\$0.06	\$0.06	s
8	Adjusted direct	Steps 2-4		=(6)+(7)+(8)	\$8.38	\$43.41	\$8.79	\$8.79	\$	\$3.77	\$3.77	-\s
(10		Step 5	MFS		36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666
Œ		Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.19	1.09	0.08	80'0		0.09	60:0	
(12)	Adj. supply cost converted	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.04	0.10	0.05	0.05		0.02	0.02	
(13)	Adj. equip cost converted	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0:00	0.01	0.12	0.12		0.00	00:00	
(14)	Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.23	1.20	0.24	0.24		0.10	0.10	
(13)	Wrk RVU	Setup File	MFS		0.97	33.64	0.22		0.22	0.17		0.17
(16)	Dir pct	Steps 6, 7	Surveys		25.6%	18.0%	28.5%	28.5%	28.5%	28.8%	28.8%	28.8%
(13)	\dashv	Steps 6, 7	Surveys		74.4%	85.0%	71.5%	71.5%	71.5%	71.2%	71.2%	71.2%
(18)	Ind. Alloc. formula (1st part)	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
(19)		Step 8		See (18)	89:0	5.48	19:0	0.61		0.26	0.26	
(20)	Ind. Alloc. formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21)		Step 8		See (20)	76.0	33.64	0:30	0.08	0.22	0.26	0.11	0.17
(22)	Indirect Allocator (1st+2nd)	Step 8		=(19)+(21)	1.65	39.12	16:0	69:0	0.22	0.51	0.37	0.17
(23)	Indirect Adjustment (Ind Adj)	Steps 9-11	See footnote**		0.367	0.367	0.367	0.367	0.367	0.367	0.367	0.367
(24)		Steps 9-11	=Ind Alloc * Ind Adj		09:0	14.35	0.33	0.25	0.08	0.19	0.14	90:0
(25)	Ind .Practice Cost Index (PCI)	Steps 12-16	See Steps 12-16		1.094	0.901	0.846	0.846	0.846	0.929	0.929	0.929
(26)	Adjusted Indirect	Step 17	= Adj. Ind Alloc*PCI	=(24)*(25)	99:0	12.92	0.28	0.22	0.07	0.18	0.13	90:0
(27)	PERVU	Steps 18-19	=(Adj Dir+Adj Ind) *budn	=((14)+(26)) *budn	68:0	14.07	0.52	0.46	0.07	0.28	0.23	0.06

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Note: Proposed PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

- * The direct adj = [current PE RVUs * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3]
- ** The indirect adj = [current PE RVUs * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10]
- 2. PE Proposals for CY 2010
- a. SMS and Supplemental Survey Background

Currently, we use PE/HR obtained from the SMS surveys from 1995–1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, we accepted and incorporated these data in developing current PE/HR values.

While the SMS survey was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multi-specialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national

representativeness. The AMA discontinued the SMS survey in 1999.

As required by the BBRA, we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 interim final rule entitled, Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data, (65 FR 25664), we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). We currently use supplemental survey data for the following specialties: Cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data are from different time periods, we have historically inflated them by the MEI to help put them on as comparable a time basis as we can when calculating the PE RVUs. This MEI proxy has been necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

b. Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs.

The AMA and our contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at http://www.cms.gov/ PhysicianFeeSched/. (See AMA PPIS Worksheets 1–3 and Lewin Group Final Report PPIS.) Table 2 shows the current indirect PE/HR based on SMS and supplemental surveys, the PPIS indirect PE/HR, and the indirect cost percentages of total costs.

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES
[Current and PPIS]

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
All Physicians.	\$59.04	\$86.36	67	74	
Allergy and Immunology	153.29	162.68	62	67	
Anesthesiology	19.76	29.37	56	82	
Audiology	59.04	72.17	67	85	All Physicians.
Cardiology	131.02	88.04	56	65	
Cardiothoracic Surgery	61.75	67.83	68	83	
Chiropractor	49.60	65.33	69	86	Internal Medicine.
Clinical Laboratory (Billing Independently)*	66.46	71.01	37	37	
Clinical Psychology	29.07	20.07	90	93	Psychiatry.
Clinical Social Work	29.07	17.80	90	97	Psychiatry.
Colon & Rectal Surgery	53.93	90.85	77	80	
Dermatology	158.49	184.62	70	70	
Emergency Medicine	36.85	38.36	88	94	
Endocrinology	49.60	84.39	69	73	
Family Medicine	52.79	90.15	62	76	
Gastroenterology	101.30	96.78	70	75	
General Practice	52.79	78.59	62	69	
General Surgery	53.93	82.74	77	82	
Geriatrics	49.60	54.14	69	74	
Hand Surgery	98.56	148.78	72	77	
Independent Diagnostic Testing Facilities *	466.16	501.45	50	50	
Internal Medicine	49.60	84.03	69	76	
Interventional Pain Medicine	59.04	156.79	67	70	
Interventional Radiology	118.48	82.55	58	81	
Medical Oncology	141.84	129.94	59	56	
Nephrology	49.60	66.00	69	80	
Neurology	66.05	110.39	74	87	
Neurosurgery	89.64	115.76	86	87	
Nuclear Medicine	118.48	39.80	58	77	
Obstetrics/Gynecology	69.74	99.32	67	67	
Ophthalmology	103.28	170.08	65	70	
Optometry	59.04	88.02	67	77	All Physicians.
Oral Surgery (Dentist only)	96.01	173.19	71	65	Otolaryngology.

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
Orthopaedic Surgery	98.56	131.40	72	81	
Osteopathic Manipulative Therapy	59.04	53.93	67	93	
Otolaryngology	96.01	141.53	71	75	
Pain Medicine	59.04	122.41	67	70	
Pathology	59.80	74.98	70	74	
Pediatrics	51.52	76.27	62	69	
Physical Medicine and Rehabilitation	84.92	110.13	71	84	
Physical Therapy	35.17	57.26	65	84	
Plastic Surgery	99.32	134.82	67	74	
Podiatry	59.04	74.76	67	82	All Physicians.
Psychiatry	29.07	30.09	90	94	
Pulmonary Disease	44.63	55.26	76	74	
Radiation Oncology (Hospital Based & Freestanding)	114.00	126.66	50	56	
Radiology	118.48	95.60	58	71	
Registered Dieticians	59.04	18.45	67	84	All Physicians.
Rheumatology	84.92	98.08	71	67	,
Urology	119.57	97.02	69	73	
Vascular Surgery	60.10	83.98	63	73	

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES—Continued [Current and PPIS]

The PPIS is a multispecialty, nationally representative, PE survey of both physician and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available to date.

As noted, the BBRA required us to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, we had required certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and to be accepted for use in the development of the PE RVUs. Because the PPIS is a contemporaneous, consistently collected, and comprehensive multispecialty survey, we do not believe similar precision requirements are necessary and are not proposing to establish them for the use of the PPIS data.

For physician specialties, the survey responses were adjusted for non-response bias. Non-response bias is the bias that results when the characteristics of survey respondents differ in meaningful ways, such as in the mix of practice sizes, from the general population. The non-response adjustment was developed based on a comparison of practice size and other characteristic information between the

PPIS survey respondents and data from the AMA Masterfile (for physician specialties) or information from specialty societies (for non-physician specialties). For six specialties (that is, chiropractors, clinical social workers, nuclear medicine, osteopathic manipulative therapy, physical therapy, and registered dietians) such an adjustment was not possible due to a lack of available characteristic data. The AMA and Lewin have indicated that the non-response weighting has only a small impact on PE/HR values.

Under our current policy, various specialties without SMS or supplemental survey data have been crosswalked to other similar specialties to obtain a proxy PE/HR. For specialties that were part of the PPIS for which we currently use a crosswalked PE/HR, we are proposing instead to use the PPIS-based PE/HR. We are proposing to continue current crosswalks for specialties that did not participate in PPIS.

Supplemental survey data on independent labs, from the College of American Pathologists, was implemented for payments in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing IDTFs, was blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments in CY 2007. Neither IDTFs nor Independent Labs participated in PPIS. Therefore, we are proposing to continue using the current PE/HR that was developed using their supplemental survey data.

We are not proposing to use the PPIS data for reproductive endocrinology, sleep medicine, and spine surgery since these specialties are not separately recognized by Medicare and we do not know how to blend this data with the Medicare recognized specialty data. We seek comment on this issue.

We are not proposing changes to the manner in which the PE/HR data are used in the current PE RVU methodology. We are merely proposing to update the PE/HR data itself based on the new survey. We propose to utilize the PE/HR developed using PPIS data for all Medicare recognized specialties that participated in the PPIS for payments effective January 1, 2010. The impact of using the new PPIS-based PE/HR is discussed in the Regulatory Impact Analysis in section V. of this proposed rule.

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we have adopted an equipment usage assumption of 50 percent. Most recently, we included a discussion in the CY 2008 PFS proposed rule on this equipment usage assumption (72 FR 38132). We noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that

^{*}Did not participate in PPIS. Data based on Supplemental Survey.

the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

The commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Certain commenters recommended we do nothing until stronger empirical evidence is available, while other commenters recommended a decrease in the utilization assumption, and some commenters recommended an increase in the utilization assumption. The particular changes recommended in the utilization assumption were, in most cases, directly related to a specific code. In the CY 2008 PFS final rule with

In the CY 2008 PFS final rule with comment period (72 FR 66232), we agreed with commenters that the equipment utilization rate should continue to be examined for accuracy. We reiterated our commitment to continue to work with interested parties on this issue. We indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

Since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue again in its March 2009 Report to Congress (see http://www.medpac.gov/documents/Mar09_EntireReport.pdf). In part of its discussion. MedPAC stated:

'In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B-6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006).32 Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker et al. 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes.³³ The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008)." (p. 108)

We believe the studies cited by MedPAC strongly suggest that our current usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. Our current 50 percent utilization rate translates into about 25 hours per week out of a 50 hour work week. The median value of 46 hours for MRIs from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For CT scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50 hour work week. We believe the studies cited by MedPAC suggest what we have long suspected, that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. All of the equipment cited in the MedPAC studies is priced over \$1 million. Therefore, we are proposing to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over \$1 million. We will continue to explore data sources regarding the utilization rates of equipment priced at less than \$1 million dollars, but are not proposing a change in the usage rate for this less expensive equipment at this

As MedPAC indicated in its report, we do not believe this proposal would create access issues in rural areas.

MedPAC noted,

"According to our analysis of data from the American Hospital Association's 2006 AHA annual survey of hospitals, 95% of rural hospitals provide CT services in their community (AHA 2007). Therefore, if rural areas do not have physician offices or freestanding centers with MRI and CT machines, most of these communities have access to such services through a hospital." (p. 110)

However, we welcome any additional analyses regarding access issues, and, as in our CY 2008 and CY 2009 rulemaking, we welcome additional empirical data relating to equipment utilization rates. Our understanding is that the PPIS survey did not produce information that can inform the utilization rate discussion, but we invite comments on this or other data sources.

d. Miscellaneous PE Issues

As we have discussed in the past rulemaking (see the CY 2008 PFS final rule with comment period (72 FR 66236) and the CY 2007 PFS final rule with comment period (71 FR 69647)),

we continue to have concerns about the issue of PE RVUs for services which are utilized 24 hours a day/7 days a week, such as certain monitoring systems. For example, the PE equipment methodology was not developed with this type of 24/7 equipment in mind. We are continuing to analyze the issue of PEs for services which are utilized 24 hours a day/7 days a week to identify any modifications to our methodology that would address the specific "constant use" issues associated with these services. Services that are currently contractor priced in CY 2009 would remain contractor priced in CY 2010. Any proposed changes will be communicated through future rulemaking.

We also received comments regarding the PE direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to several high dose radiation therapy (HDRT) and placement CPT codes. Based on our review of these codes and comments received, we are requesting that the AMA RUC consider these CPT codes for additional review.

e. AMA RUC Recommendations for Direct PE Inputs

The AMA RUC provided recommendations for PE inputs for the codes listed in Table 3.

TABLE 3—CODES WITH AMA RUC PE RECOMMENDATIONS

CPT ¹ code	Description
37183 47382 50200 55873 93025	Biopsy of kidney. Cryoablate prostate.

¹ CPT codes and descriptions are Copyright 2009 American Medical Association.

We are in agreement with the AMA RUC recommendations for the direct PE inputs for the codes listed in Table 3 and propose to adopt these for CY 2010.

B. Geographic Practice Cost Indices (GPCIs): Locality Discussion

1. Update—Expiration of 1.0 Work GPCI Floor

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of

the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. We also noted that section 134 of the MIPPA extended the 1.000 work GPCI floor from July 1, 2008, through December 31, 2009. (Note: The 1.000 work GPCI floor was enacted and implemented for CY 2006, and, prior to enactment of the MIPPA, was set to expire on June 30, 2008.) Additionally, section 1848(e)(1)(G) of the Act, as amended by section 134(b) of the MIPPA, set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Therefore, as required by the MIPPA, beginning on January 1, 2010, the 1.000 work GPCI floor will be removed. However, the 1.500 work GPCI floor for Alaska will remain in place. See Addenda D and E of this proposed rule for the GPCIs and summarized geographic adjustment factors (GAFs), respectively.

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (this is, work, PE, and malpractice). Payments under the PFS are based on the relative resources involved in furnishing physicians' services, and are adjusted for differences in relative resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities.

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities including 37 higher-cost areas; 16 Rest of State areas (comprising the remaining counties not located in a higher-cost area within a State); 34 Statewide areas; and Puerto Rico and the Virgin Islands which are designated as "territory-wide" localities. The development of the current locality structure is described in detail in the CY 1997 PFS

proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner. Therefore, any change in localities can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

For the past several years, we have been involved in discussions with California physicians and their representatives about recent shifts in relative demographics and economic conditions among a number of counties within the current California payment locality structure. In the CY 2008 PFS proposed rule and final rule with comment period, we described three potential options for changing the payment localities in California (72 FR 38139 and 72 FR 66245, respectively).

After reviewing the comments on these options, we decided not to proceed with implementing any of them at that time. We explained that there was no consensus among the California medical community as to which, if any, of the options would be most acceptable. We also received suggestions from the Medicare Payment Advisory Commission (MedPAC) for developing changes in payment localities for the entire country and other States expressed interest in having their payment localities reconfigured as well. In addition, other commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time. Because of the divergent views expressed in comments, we explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking.

Interim Study of Alternative Payment Localities Under the PFS

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC

(Acumen), to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, "Review of Alternative GPCI Payment Locality Structures," is still accessible from the CMS PFS Web page under the heading "Interim Study of Alternative Payment Localities under the PFS." The report may also be accessed directly from the following link: http://www.cms.hhs.gov/ PhysicianFeeSched/ 10 Interim Study.asp#TopOfPage. We accepted comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

Option 1: CMS Core Based Statistical Area (CBSA) Payment Locality Configuration

This option uses the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the inpatient hospital prospective payment system (IPPS) pre-reclassification CBSA assignments and with the geographic payment adjustments used in other Medicare payment systems. This option would increase the number of localities from 89 to 439.

Option 2: Separate High Cost Counties From Existing Localities (Separate Counties)

Under this approach, higher cost counties are removed from their existing locality structure and they would each be placed into their own locality. This option would increase the number of localities from 89 to 214 using a 5 percent GAF differential to separate high cost counties.

Option 3: Separate MSAs From Statewide Localities (Separate MSAs)

This option begins with Statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in option 2). This option would increase the number of localities from 89 to 130 using a 5 percent GAF differential to separate high cost MSAs.

Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers)

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of localities from 89 to 140 using a 5 percent GAF differential to group similar counties into Statewide tiers.

Additionally, as discussed in the interim locality study report, our contractor, Acumen, applied a "smoothing" adjustment to the current PFS locality structure, as well as to each of the alternative locality configurations (except option 4: Statewide Tiers). The "smoothing" adjustment was applied to mitigate large payment differences (or payment "cliffs") between adjacent counties. Since large payment differences between adjacent counties could influence a physician's decision on a practice location (and possibly impact access to care), the "smoothing" adjustment was applied to ensure that GAF differences between adjacent counties do not exceed 10 percent. (For more information on the "smoothing" adjustment see the interim locality study report on the PFS Web page via the link provided above.)

b. Summary of Public Comments on Interim Locality Study Report

In the CY 2009 PFS proposed rule (73 FR 38514), we encouraged interested parties to submit comments on the options presented both in the proposed rule and in the interim report posted on our Web site. We also requested comments and suggestions on other potential alternative locality configurations (in addition to the options described in the report). Additionally, we requested comments on the administrative and operational issues associated with the various options under consideration. We also emphasized that we would not be proposing any changes to the current PFS locality structure for CY 2009 and that we would provide extensive opportunities for public comment before proposing any change. The following is a summary of the comments received on the alternative locality options discussed in the CY 2009 PFS proposed rule and interim locality study report.

(1) Introduction and General Support for Change

We received approximately 200 comments on the CY 2009 PFS proposed rule and locality study report from various specialty groups, medical societies, State medical associations,

individual practitioners, and beneficiaries. Commenters generally commended us for acknowledging the need to reconfigure PFS payment localities and expressed support for our study of alternative locality configurations. Many commenters urged us to expedite changes to the current locality structure in order to accurately reflect the geographic cost differences of operating a medical practice. For example, the Connecticut State Medical Society commented that the current locality configuration contributes to medical access issues and problems with recruitment and retention of practitioners (with an emphasis on access to primary care).

Another commenter stated that Ohio's Statewide locality configuration needs to be changed because a Statewide locality designation does not account for the (presumably higher) cost of operating a medical practice in northern Ohio. The commenter also objected to the agency's approach to requests for changes to the current locality structure (which includes an assessment of support for the changes by the medical community, including the relevant State medical associations). The commenter believes the State medical association does not represent all of the physicians in Ohio.

Another commenter stated that a change in the PFS locality structure is long overdue. The commenter stated that San Diego County is the most underpaid area in the nation and that grouping that county with the Rest of California locality is erroneous. Moreover, several commenters stated that a timely reassessment is needed and urged us to update the locality structure every 3 years. Two commenters believe that previous studies completed on the PFS locality structure by MedPAC, GAO, Urban Institute, as well as the current study by Acumen, support immediate reform to the current PFS locality structure.

We received many comments from hospitals and physicians located in Frederick County Maryland (which is currently grouped with the Rest of Maryland locality). The commenters support each of the alternative locality configurations we presented because each option results in PFS payment increases for services furnished in Frederick County. The commenters stated that Frederick County is considered a 'bedroom community' for the DC/Northern Virginia area, has experienced the highest growth rate in the State, and noted that the cost of living has increased significantly. Additionally, the commenters noted that the last economic census aligns

costs in Frederick County with those in Montgomery County (whose doctors receive higher payment amounts) and that Frederick County competes with physician practices in Montgomery County for professional staff. Moreover, the commenters believe that because of inadequate PFS payment amounts, access to care is becoming a problem and emergency room visits are on the rise.

(2) Cautious Approach

Some commenters requested that we take a cautious approach to reconfiguring the locality structure. For instance, the Texas Medical Association stated that because of the redistributive impact that results from any locality reconfiguration, CMS should avoid making large scale changes at one time. Additionally, another commenter stated that "stakeholders" should be given a long advance notification period (at least 2 full calendar years) prior to the effective date of any changes to the PFS locality configuration. The commenter also stated that the current locality structure should remain in place (for each locality) unless the need for revision is strongly substantiated because of a change in practice cost patterns. A specialty society expressed support for postponing any adjustments for at least 1 year to allow for more discussion between CMS and "stakeholders".

(3) Guiding Principles

We received several comments from California that suggested a set of goals for reforming the PFS payment locality structure. The goals suggested by the commenters are as follows:

- Improve payment accuracy (as compared to the current locality structure);
- Move towards MSA-based localities;
- Mitigate payment reductions to rural California areas (and therefore minimize corresponding negative impact on access to care in California);

• Promote administrative simplification by aligning physician and hospital payment localities.

The California Medical Association (CMA) urged us to apply a consistent methodology across all payment localities and requested that any revision to the localities include a "formula driven" mechanism that can be applied repeatedly to future revisions. A California county medical society stated that more specific objectives for reforming PFS payment localities should be developed. For example, the commenter suggested that

payment reductions for practitioners should not exceed 1.5 percent in any given year, GAF differentials between adjacent localities should not exceed 10 percent, and that contiguous localities with less than a 1 percent difference in their GAF's should be combined into a single locality.

(4) Comments on the Studied Alternative Locality Options

We received many comments on the options for reconfiguring PFS payment localities presented in the interim locality study report. One commenter stated that option 1 (the CMS CBSA locality configuration) is the best option because it provides the greatest payment accuracy. The same commenter also stated that using CBSAs as the PFS locality definition would be similar to other Medicare payment systems (for example, the IPPS). Therefore, the commenter believed that geographic payment adjustments for physicians and hospitals would be consistent for a given geographic area. The CMA and a California county medical society stated that although option 1 would provide the greatest payment accuracy, it would also lead to significant payment reductions for many counties. Those same commenters expressed concern with the negative impact of transitioning directly to the CMS CBSA locality configuration. If adopted, the commenters suggested that the CMS CBSA locality configuration be implemented in stages over several years. The Texas Medical Association echoed this concern and urged us not to adopt option 1 unless we employ a hold harmless floor along with "material" increases in the conversion factor.

The Texas Medical Association also stated that option 2 (Separate High Cost Counties from Existing Localities) results in less significant payment reductions to rural practitioners, as compared to the reductions seen under option 1 (CMS CBSA) and option 4 (Statewide Tiers). However, the commenter did not support option 2 because it would create different localities within major urban areas and, therefore, provide incentives for "border-crossing," (in other words, incentives for physicians to move their medical practice to an adjacent urbanized county to obtain a higher payment amount). Additionally, the Texas Medical Association stated that option 2 increases administrative complexity due to the additional number of localities and the need to reallocate source data into smaller (county level) areas. The CMA also stated that option 2 results in less significant payment reductions (as

compared to the other options). However, the CMA stated that option 2 continues to produce inaccurate payments because it applies MSA-based data to county-based localities.

Many commenters from the State of California expressed support for option 3 (Separate High Cost MSAs from Statewide Localities) because the commenters believed it would improve payment accuracy (over the current locality configuration) and at the same time mitigate the payment reductions to rural areas that would occur under option 1 (CMS CBSA) and option 4 (Statewide Tiers). The CMA explained that selecting an MSA-based locality approach would provide consistency with the hospital payment system and enable physicians to better compete with hospitals for the local work force. For example, the commenters stated that hospitals located in the Santa Cruz MSA are some of the highest paid in the nation. However, under the PFS locality structure, Santa Cruz County is grouped with the Rest of California locality, which is the lowest paid PFS locality in the State.

The Texas Medical Association suggested that we adopt option 3 because it minimizes payment reductions to lower cost rural areas. For example, since option 3 results in the fewest payment localities (as compared to the other alternative locality configurations), it reduces the redistribution effects of separating higher cost areas from rural "rest of State" areas. The commenter also stated that option 3 (Separate MSAs) matches payment with the underlying data better than option 2 (Separate Counties) and option 4 (Statewide Tiers). Some commenters expressed their belief that MSAs are better basic locality units than counties because the cost data is more reliably derived directly from MSAs (instead of counties). Several commenters who supported the adoption of an MSA-based PFS locality structure suggested that option 3 could be used as a transition to the CMS CBSA locality configuration (option 1).

With regard to option 4 (Statewide Tiers), the Texas Medical Association stated that the Statewide Tiers locality configuration creates payment areas that are poorly aligned with the underlying data and results in unacceptable payment decreases to small urban and rural areas. The Florida Medical Association explained that many localities have experienced a shift in population and economic development since the last PFS locality reconfiguration. The commenter stated that counties with similar costs should be grouped together in the same locality

regardless of geographic location and that the Statewide cost tier locality structure (option 4) would accomplish this objective. The CMA stated that under option 4, counties are not geographically contiguous and noted that the counties grouped together in a locality may not be related to one another economically. The commenter suggested that noncontiguous counties may experience more frequent economic changes than contiguous counties. The commenter expressed concern that option 4 would need to be updated more frequently and therefore payments to physicians will fluctuate more often. A California county medical society stated that option 4 creates payment errors for counties in seven California localities that currently have accurate payments. The Connecticut State Medical Society stated that New Haven County would experience an increase under option 4.

(5) Smoothing Adjustment

Many commenters from the State of California did not support the concept of "smoothing" because it would require payment reductions for higher cost counties to offset the increases given to lower cost counties (in order to achieve budget neutrality). Additionally, the same commenters stated that physicians in "smoothed" counties benefit financially from the smoothing adjustment solely because they are located adjacent to high cost areas. They also stated that a "smoothing" adjustment would be complex to administer, and difficult to understand. The CMA, a California county medical society, and another commenter from California stated that a "smoothing" adjustment would require a change in the statute and that current Medicare statute requires GPCIs to reflect the relative costs differences among localities for work, PE, and malpractice expense. Another commenter recommended that we study the extent to which a "smoothing" adjustment can be used as a temporary measure; in order to phase-in significant changes in payment levels resulting from a PFS locality reconfiguration.

(6) Other Alternative Options

A few commenters submitted suggestions on other potential alternative PFS locality configurations in addition to those discussed in the interim report. For example, one medical clinic suggested a "market-based" approach instead of the current "cost-based" methodology. Under this approach, PFS payment would be geographically adjusted based on the ratio of Medicare participating

physicians to Medicare beneficiaries. The commenter suggested that payment amounts should be increased in geographic areas with a low physician to Medicare beneficiary ratio (for example, 1 physician for every 3,000 beneficiaries) and decreased in areas with a higher ratio (for example, 1 physician for every 200 beneficiaries). The commenter stated that "this process could be used to bring physician to patient ratios in the United States to equilibrium."

The CMA and a California county medical society suggested variations of option 2 (Separate Counties) with the intention of reducing the number of localities that would result under this option. The commenters suggested adopting a "basic locality unit" (for example, MSA) instead of a county when removing areas from an existing locality. For example, if 5 counties are removed from a "Rest of State" locality, and included within the same MSA, the 5 counties would be grouped into a single new locality rather than 5 separate new localities. The commenter also suggested that if removed counties are contiguous and have similar costs (even if not part of same MSA); they should be consolidated into one new locality instead of separate localities. The commenters stated that either of these variations would reduce the number of new localities created under option 2.

Additionally, the CMA and a California county medical society suggested a variation of option 4 (Statewide Tiers). The commenters stated that fixed cost tiers be established for each State using .05 GAF increments which would lock in the upper and lower GAF values for each cost tier. Under this approach, the fixed cost tiers would not change based on updates to the GPCIs; however, a county could be moved to a lower (or higher) cost tier without the need to define new tiers for the entire state.

(7) Redistribution of Payment

Many commenters acknowledged that a significant redistribution of payments would occur under each alternative locality configuration option and requested that we minimize the payment discrepancy between urban and rural areas to ensure continued access to services. Additionally several commenters stated that any changes to the locality configuration should not be unfair to rural practitioners. One specialty college noted that any new locality configuration must be budget neutral, resulting in a shift of resources from one geographic area to another. The commenter expressed concern that

the requirement for budget neutrality may help physicians who practice in certain geographic areas, but will be costly to others. As such, the commenters stated that each alternative PFS locality option could create problems for medical access in areas where payments are reduced. As a method to minimize payment reduction, a few commenters requested that we continue the application of the 1.0 work GPCI floor.

The AMA stated that any proposal to reconfigure PFS payment localities should not necessitate budget-neutral payment redistributions. The commenter expressed the concern raised by other commenters that some localities would receive payment increases under some options while other localities would experience significant payment reductions to offset these increases. The commenters requested that if new locality definitions are proposed, new funding should be provided to increase payments in localities that are found to be underpaid. The commenters also stated that budget neutral redistributions would only exacerbate an already flawed and under-funded Medicare PFS. The AMA suggested that States with a Statewide locality should be given the option of remaining a Statewide locality and that CMS should continue its policy of allowing any State the option of converting to a Statewide locality at the request of the State Medical Association.

The Iowa Medical Society stated that Medicare PFS payment levels in Iowa are among the lowest in the country and that the four alternative locality configurations all appear to further reduce payments to State physicians. As such, they requested that Iowa remain a Statewide locality under any nationwide locality change.

Because of the redistribution effect of any locality reconfiguration, some commenters did not find any of the potential alternative locality configurations preferable to the current payment locality structure. For example, one physician academy stated that all four of the alternative locality scenarios result in disproportionately lower GAFs for non-MSA counties. Therefore, the commenter encouraged us to maintain the current locality structure until we identify an alternative that decreases the number of payment localities and supports practitioners in rural and underserved areas. The commenter also expressed support for a locality reconfiguration that minimizes the number of payment localities; does not exceed the current number of 89 localities and eliminates geographic

payment adjustments (except those designed to encourage physicians to practice in underserved areas). Furthermore, the Florida Medical Association urged us to work with Congress to remove the application of budget neutrality when making changes to the PFS payment locality structure. The commenter suggested that we use the current GCPI values as a "floor" to ensure that future updates to the localities will not result in payment reductions.

(8) Methodology

The CMA and a California county medical society commended the contractor, Acumen, for the accuracy of its calculations, modeling of the options, and observations. However, they recommended a change in the iterative methodology used to develop option 2 and option 3. The commenters stated that the threshold for removing high cost counties from existing localities (option 2) and removing high cost MSAs from Statewide localities (option 3) should be equal to or greater than 5 percent (not just greater than 5 percent) with no rounding up for GAF differences below 5 percent. Additionally, with regard to option 2, the commenters recommended that counties with identical GAFs to the county being considered for a new locality should not be included in the calculation of the "Rest of Locality" GAF (which is used for comparison to the higher cost county).

Additionally, the commenters objected to the methodology used for the "smoothing" adjustment. The commenters believe that a new locality created by smoothing should not have a significantly lower GAF than it would if the county was a single locality. For example, the commenters noted that San Diego County (which is currently included in the Rest of California locality) has a county-level GAF of 1.056. However, when the smoothing adjustment is applied to the current locality configuration, the GAF for San Diego is 1.018.

One research institute questioned why high cost counties were separated from existing localities (option 2) and high cost MSAs were separated from Statewide localities (option 3); instead of separating low cost counties and low cost MSAs. The commenter stated that the CMS CBSA methodology is not designed to be sensitive enough to detect significant geographic differences in physician compensation and PE. The commenter questioned whether compensation and PE costs are correlated directly with population density.

Clarification on Methodology Used To Develop Alternative Locality Configurations Discussed in the Interim Report

With regard to the iterative methodology used for option 2 and option 3, the contractor, Acumen, analyzed these alternative locality configurations based on its understanding of the MedPAC ideas. A threshold of greater than 5 percent was used to separate high cost counties from existing localities (option 2) and to separate high cost MSAs from Statewide localities (option 3). Additionally, the contractor compared just one county (or MSA) at a time against the weighted average GAF of all the lower-ranked counties in the Medicare locality. Counties with the same GAF were not treated as a group. In ranking counties by GAF, the contractor used physician work RVUs to break "ties." In other words, when two counties in a Medicare locality had the same GAF, the county with the higher physician work RVU was ranked as if it had the higher GAF. Keeping counties with identical GAFs together would be another possible strategy for developing alternative PFS payment localities. The high cost counties and MSAs were removed in the iterative process to reflect ongoing concerns regarding individual high cost counties (usually in "rest of state" areas) where the GAF is significantly higher than the norm for the locality. Removing low cost counties would isolate very low cost areas leading to further reductions in PFS payment levels for physicians and practitioners in these

With regard to the sensitivity of the CBSA methodology and whether compensation and PE cost are correlated directly to population density; the CBSA methodology has three types of areas: MSAs, Metropolitan Divisions within MSAs, and non-MSA areas. None of these definitions involve population density per se, although MSAs must include core areas with populations of 50,000 or greater. Given that the CBSA methodology has more regions than the other alternative locality configurations, it could potentially draw on more detailed levels of data than the other options, and therefore, result in a more precise reflection of geographic cost differences.

(9) Suggested Additional Topics for Review

One commenter stated that the interim locality study report should have addressed how a change in payment locality structure might impact a physician's choice regarding practice

location and Medicare beneficiary access to physician services.

The CMA and a California county medical society stated that the interim locality study should have included a discussion of payment accuracy under the current locality structure and under each potential locality configuration. The commenters stated that a discussion of the potential negative impact under a particular option without a discussion of the accuracy of payment for each option is misleading. Additionally, they suggested adding a discussion of potential methods to mitigate payment reductions.

(10) Administrative and Operational Issues

We received few comments on administrative and operational issues related to making changes to the PFS payment locality structure. Some commenters stated that a locality revision would impose a minimal amount of additional administrative burden. However, the commenters did not specify whose administrative burden they were assessing. One commenter stated that implementing the CMS CBSA locality configuration (option 1) would be a significant administrative burden. Additionally, one health care plan explained that many Medicare Advantage Plans are based on Medicare fees in specific localities. As such, any fee schedule locality revision would be a large scale and costly administrative undertaking for managed care plans as well as for "traditional" Medicare.

(11) Underlying Data

We also received comments on the data used to develop GPCI values. Although we appreciate these comments, the focus of the interim locality study was not intended to be a review of the underlying data sources used to develop GPCI values. As discussed earlier, the interim locality study was a review of potential approaches for redefining the Medicare PFS payment localities.

Response to Comments

We would like to thank the public for the many thoughtful comments on the interim locality study report entitled, "Review of Alternative GPCI Payment Locality Structures". As noted by the commenters and reflected in the report, significant payment redistribution would occur if a nationwide change in the PFS locality configuration were undertaken. All four of the potential alternative payment locality configurations reviewed in the report would increase the number of localities

and separate higher cost, typically urban areas from lower cost, typically rural "Rest of State" areas. In general, payments to urban areas would increase while rural areas would see a decrease in payment under each of the options studied because they would no longer be grouped with higher cost "urbanized" areas. We intend to review the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations. We will also explore whether alternative underlying data sources are available nationwide. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches.

We are not proposing changes in the PFS locality structure at this time. As explained in the CY 2009 PFS final rule with comment period, in the event we decide to make a specific proposal for changing the locality configuration, we would provide extensive opportunities for public input (for example, town hall meetings or open door forums, as well as opportunities for public comments afforded by the rulemaking process).

C. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In this current rule, we are proposing to implement the second review and update of malpractice RVUs.

2. Proposed Methodology for the Revision of Resource-Based Malpractice RVIIs

The proposed malpractice RVUs were developed by Acumen, LLC (Acumen) under contract to us.

The methodology used in calculating the proposed second review and update of resource-based malpractice RVUs largely parallels the process used in the CY 2005 update. The calculation requires information on malpractice premiums, linked to the physician work conducted by different specialties that furnish Medicare services. Because malpractice costs vary by State and specialty, the malpractice premium information must be weighted geographically and across specialties. Accordingly, the proposed malpractice expense RVUs are based upon three data sources:

• Actual CY 2006 and CY 2007 malpractice premium data.

• CY 2008 Medicare payment data on allowed services and charges.

 CY 2008 Geographic adjustment data for malpractice premiums.

Similar to the previous update of the resource-based malpractice expense RVUs, we are proposing to revise the RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available through State Departments of Insurance. We propose to use actual CY 2006 and CY 2007 malpractice premium data because they are the most current data available (CY 2008 malpractice premium data were not consistently available during the data collection process). Accounting for market shares, three fourths of all included rate filings were implemented in CY 2006 and CY 2007. The remaining rate filings were implemented in CY 2003 through CY 2005 but still effective in CY 2006 and CY 2007. Carriers submit rate filings to their State Departments of Insurance listing the premiums and other features of their coverage. The rate filings include an effective date, which is the date the premiums go into effect. Some States require premium changes to be approved before their effective date; others just require the rate filings to be

submitted. We try to capture at least 2 companies and at least 50 percent of the market share, starting with the largest carriers in a State.

The primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history. We collected malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers. Rate filings were not available through Departments of Insurance in Mississippi or Puerto Rico. Premiums were for \$1 million/\$3 million, mature, claims-made policies (policies covering claims made, rather than services furnished during the policy term). A \$1 million/\$3 million liability limit policy means that the most that would be paid on any claim is \$1 million and that the most that the policy would pay for several claims over the timeframe of the policy is \$3 million. We collected data from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory surcharges for patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) in States where PCF participation is mandatory. We sought to collect premium data representing at least 50 percent of physician malpractice premiums paid in each State as identified by State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Rather than select the top 20 physician specialties as when the malpractice RVU were originally established and updated, we included premium information for all physician and surgeon specialties and risk classifications available in the collected rate filings. Most insurance companies provided crosswalks from insurance services office (ISO) codes to named specialties; we matched these

crosswalks to CMS specialty codes. We also preserved information obtained regarding surgery classes, which are categorizations that affect premium rates. For example, many insurance companies grouped general practice physicians into nonsurgical, minorsurgical and major-surgical classes, each with different malpractice premiums. Some companies provided additional surgical subclasses; for example, distinguishing general practice physicians that conducted obstetric procedures, which further impacted malpractice rates. We standardized this information to CMS specialty codes.

We could not identify malpractice premium rates through typical malpractice rate filings for some physician specialties, nonphysician practitioners (NPPs), and other entities (for example, independent diagnostic testing facilities (IDTFs)) paid under the PFS. In the absence of available premium data for these specialties and entities, we took a number of steps.

We collected data from one of the largest association program insurance brokers and administrators in the United States providing malpractice insurance to medical physicists. We incorporated the data into the calculation of the proposed update to the malpractice RVUs for TC services. (See section II.C.3 of this proposed rule for a discussion of this issue.)

We also crosswalked 13 specialties for which there was not significant collected data available (those in less than 35 States' malpractice premium rate filings) to similar specialties and risk classes. The unassigned specialties and the specialty to which we are proposing to assign them are shown in Table 4. The remaining four specialties were dropped, meaning they were not included in the weighted averages for calculating the malpractice RVUs.

Note: While we were able to collect data on many more specialties on this survey than under the previous one, these four specialties were also dropped under the previous version of the survey because of a lack of available data. This left 44 specialties, representing 90 percent of Medicare services, for which we used the malpractice premium data to develop risk factors.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
19 35	Interventional Pain Management Oral Surgery Chiropractic Psychologist	03 03	Pain Management. Allergy Immunology*. Allergy Immunology*. Allergy Immunology*.
	Physical Therapist		Allergy Immunology*.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES—Continued

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
68	Occupational Therapist Clinical Psychologist Addiction Medicine Maxillofacial Surgery Neuropsychiatry Surgical Oncology Interventional Radiology Gynecological/Oncology	03 03 03 03 26 02 30 90	Allergy Immunology*. Allergy Immunology*. Allergy Immunology*. Allergy Immunology*. Psychiatry. General Surgery. Diagnostic Radiology. Medical Oncology.
	Unknown Physician Specialty	01	General Practice.

^{*}Lowest Physician Specialty.

The methodology presented in this proposed rule conceptually follows the specialty-weighted approach used in the CY 2000 and CY 2005 PFS final rules with comment period (63 FR 59383 and 69 FR 66263, respectively) and incorporates the minor modifications discussed in the CY 2006 final rule with comment period (70 FR 70153). We revised the current specialty-weighted approach to accommodate additional data gathered during the malpractice premium data collection. The specialtyweighted approach bases the malpractice RVUs upon a weighted average of the risk factors of all specialties furnishing a given service. This approach ensures that all specialties furnishing a given service are accounted for in the calculation of the

final malpractice RVUs. Our proposed methodology is as follows:

(1) Compute a preliminary national average premium for each specialty. Insurance rating area malpractice premiums for each specialty were mapped to the county level. The specialty premium for each county is then multiplied by the total county RVUs (as defined by Medicare claims data), which had been divided by the malpractice GPCI applicable to each county to standardize the relative values for geographic variations. If the malpractice RVUs were not normalized for geographic variation, the locality cost differences (as reflected by the GPCIs) would be counted twice. The product of the malpractice premiums and standardized RVUs is then summed across counties for each specialty. This

calculation is then divided by the total RVUs for all counties, for each specialty, to yield a national average premium for each specialty.

(2) Determine which risk class(es) to use within each specialty. Many specialties had premium rates that differed for major surgery, minor surgery, and no surgery. These surgery classes are designed to reflect differences in risk of professional liability and the cost of malpractice claims if they occur. The same concept applies to procedures; some procedures carry greater liability risks. Accordingly, we identified major, minor, nonsurgical, and obstetric procedures among all Medicare procedures by established indicators (Global Surgery Flags). Table 5 shows the surgery class definitions used in the proposed methodology.

TABLE 5—SURGERY CLASSES BY PROCEDURE CODE

Surgery class	CPT code range	Global surgery flag
Major Surgery (Maj) Minor Surgery (Min) Obstetrics (OB) No Surgery (NS)	10000–69999	90 Day. All Other. N/A. N/A.

To account for the presence of surgery classes in the malpractice premium data and the task of mapping these premiums to procedures, we sought to calculate distinct risk factors for major, minor, and nonsurgical procedures, as well as a comparable approach for obstetric premiums and procedures. However, the availability of data by surgery class varied across specialties. In light of the complexity of the surgery class data, we evaluated both the frequency with which rate class data were reported and a preliminary set of normed national average premiums, calculated for all classes reported in the data. Because no single approach accurately addressed the risk weights and value differences of various specialty/procedure combinations, we developed five strategies for handling the surgical

classes and defining specialties. These strategies are summarized in Table 6.

(a) Substantial Data for Each Class: For 13 out of 44 specialties, we determined that there was sufficient data for each surgical class, as well as sufficient differences in rates between classes, to use the surgical class data as the basis for risk factors by surgical class.

(b) Major Surgery Dominates: These 8 surgical specialties typically had rate filings that specified major surgery as the predominate rate reported. Filings that distinguished minor surgery or nonsurgical were relatively rare. For most of these surgical specialties, we did not have "unspecified" rate filings. When we had "unspecified" rate filings, the unspecified category was sometimes above and sometimes below the major

surgery rate. For these cases, we assigned the premium for major surgery to all procedures conducted by this specialty. (In practice, the major surgery procedures dominate the services actually furnished.)

(c) Little or No Data for Major Surgery: For five other specialties, specific premiums for major surgery were uncommon, but most States had rate filings that represented minor surgery or nonsurgical coverage. These five specialties had unspecified rates that were less common than the minor surgery-nonsurgery distinction and the nonsurgery rates. Therefore, for these five specialties we assigned the minor surgery rate filings for both major surgery and minor surgery procedures, and the nonsurgery filings for nonsurgical procedures.

(d) Unspecified Dominates: Many malpractice rate filings did not specify surgery classes for some specialties; we refer to these instances as unspecified malpractice rates. In only two cases, we choose the unspecified premium as the premium information to use for the specialty. For both of these specialties, fewer than 20 States had rate filings that distinguished by surgical classes, while

more than 40 had general rate filings for the specialty.

(e) Blend All Available: For the last 16 specialties, there was wide variation across the State filings in terms of whether or not surgical classes were reported and which categories were reported. Because there was no clear strategy for these remaining specialties, we blended the rate information we

collected into one general premium rate and applied that rate for all three premiums (major, minor and nonsurgical). For these specialties, we developed a weighted average "blended" premium at the national level, according to the percentage of physician work RVUs correlated with the surgery classes within each specialty.

TABLE 6—SUMMARY OF APPROACHES TO DEFINING PREMIUMS BY SURGICAL CLASS

Situation	Specialty codes
1. Substantial Data for Each Class (13)	01 (non-OB), 04, 06, 07. 08 (non-OB), 10, 13, 18. 16 (non-OB), 38, 39, 46, 93.
Major Surgery Dominates (8) Little or No Data for Major Surgery (5) Unspecified Dominates (2)	11, 22, 37, 44, 82. 05, 72.
5. Blend All Available (16)	03, 25, 26, 29, 30, 34, 36, 40, 48, 66, 71, 81, 83, 84, 90, 92.

For rarely-billed Medicare procedures, we did not apply the 5 percent threshold for inclusion of services or specialties as utilized in previous MP RVU updates. Rather, we are proposing to use the risk factor of the dominant specialty by services for each procedure for which the number of allowed services is less than 100. This approach reflects the risk factors of the

specialty that most frequently furnishes these low volume procedures.

(3) Calculate a risk factor for each specialty. Differences among specialties in malpractice premiums are a direct reflection of the malpractice risk associated with the services furnished by a given specialty. The relative differences in national average premiums between various specialties

can be expressed as a specialty risk factor. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, allergy/immunology. Table 7 shows the risk factors by specialty and surgery class.

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
1	General Practice	1.50	2.26	3.56
2	General Surgery	5.87	5.87	5.87
3	Allergy Immunology	1.00	1.00	1.00
4	Otolaryngology	1.44	2.37	3.55
5	Anesthesiology	2.22	2.22	2.22
6	Cardiology	1.87	2.65	6.09
7	Dermatology	1.14	2.06	3.96
8	Family Practice	1.57	2.23	3.79
10	Gastroenterology	2.03	2.48	4.09
11	Internal Medicine	1.72	2.52	2.52
13	Neurology	2.20	2.90	10.28
14	Neurosurgery	9.94	9.94	9.94
16	Obstetrics Gynecology	1.67	2.37	4.64
18	Ophthalmology	1.07	1.68	1.90
19	Oral Surgery	1.00	1.00	1.00
20	Orthopedic Surgery	5.46	5.46	5.46
22	Pathology	1.74	2.26	2.26
24	Plastic and Reconstructive Surgery	5.51	5.51	5.51
25	Physical Medicine and Rehabilitation	1.14	1.14	1.14
26	Psychiatry	1.22	1.22	1.22
28	Colorectal Surgery	3.99	3.99	3.99
29	Pulmonary Disease	2.08	2.08	2.08
30	Diagnostic Radiology	2.62	2.62	2.62
33	Thoracic Surgery	6.51	6.51	6.51
34	Urology	2.64	2.64	2.64
35	Chiropractic	1.00	1.00	1.00
36	Nuclear Medicine	1.55	1.55	1.55
37	Pediatric Medicine	1.49	2.41	2.41
38	Geriatric Medicine	1.43	2.23	4.22
39	Nephrology	1.61	2.27	4.17
40	Hand Surgery	3.49	3.49	3.49
44	Infectious Disease	2.09	2.52	2.52
46	Endocrinology	1.51	2.23	4.46

3.56

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
48	Podiatry	1.98	1.98	1.98
62	Psychologist	1.00	1.00	1.00
65	Physical Therapist	1.00	1.00	1.00
66	Rheumatology	1.56	1.56	1.56
67	Occupational Therapist	1.00	1.00	1.00
68		1.00	1.00	1.00
71	Registered Dietitian/Nutrition Professional	1.54	1.54	1.54
72	Pain Management	2.21	2.21	2.21
77	Vascular Surgery	6.50	6.50	6.50
78	Cardiac Surgery	6.89	6.89	6.89
79	Addiction Medicine	1.00	1.00	1.00
81	Critical Care (Intensivists)	2.15	2.15	2.15
82	Hematology	1.59	2.03	2.03
83	Hematology/Oncology	1.72	1.72	1.72
84	Preventive Medicine	1.16	1.16	1.16
85	Maxillofacial Surgery	1.00	1.00	1.00
86	Neuropsychiatry	1.22	1.22	1.22
90	Medical Oncology	1.76	1.76	1.76
91	Surgical Oncology	5.87	5.87	5.87
92	Radiation Oncology	2.30	2.30	2.30
93		2.29	3.77	4.87
94	Interventional Radiology	2.62	2.62	2.62
98	Gynecological/Oncology	1.76	1.76	1.76

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS—Continued

One complication in the calculation of specialty risk factors is technical component (TC) data. Many procedures are comprised of professional components (PC) and TCs. These components are referred to as global procedures when billed together. The TC represents the cost of equipment, supplies, and technician/staff salaries involved in furnishing a procedure, such as the taking of an x-ray by a technician. The PC represents the portion of a service that is furnished by a physician such as the interpretation of an x-ray by the physician. The distinction is important because PCs and TCs have different associated risk factors and face different malpractice insurance costs. The previous update of the malpractice RVUs did not update the TCs due to the lack of available malpractice premium data for entities providing TC services. In the past, we were unable to obtain data concerning malpractice costs associated with the TC, so we based the malpractice RVUs for TC services and the TC portion of global services on historical allowed

We have had ongoing discussions with the AMA RUC and various specialty societies about this issue. In the CY 2008 PFS proposed rule (72 FR 38143), we noted that the Professional Liability Insurance (PLI) workgroup, a subset of the AMA RUC brought to our attention the fact that there are approximately 600 services that have TC malpractice RVUs that are greater than the PC malpractice RVUs. The PLI

workgroup requested that we make changes to these malpractice RVUs and suggested that it is illogical for the malpractice RVUs for the TC of a service to be higher than the malpractice RVUs for the PC.

Unknown Physician Specialty

We responded that we would like to develop a resource-based methodology for the technical portion of these malpractice RVUs; but that we did not have data to support such a change. We asked for information about whether, and if so, how technicians employed by facilities purchase PLI or how their professional liability is covered. We also asked for comments on what types of PLI are carried by entities that furnish these technical services.

In the CY 2009 PFS proposed rule (73 $\,$ FR 38515), we stated that the issue of assigning malpractice RVUs for the TC of certain services continues to be a source of concern for several physician associations and for CMS. We noted that we did not receive a response to our CY 2008 request for additional data on this issue and that this issue is one of importance to CMS. We also stated that the lack of available PLI data affects our ability to make a resource-based evaluation of the TC malpractice RVUs for these codes. We indicated that as part of our work to update the malpractice RVUs in CY 2010, we would instruct our contractor to research available data sources for the malpractice costs associated with the TC portion of these codes and that we would also ask the contractor to look at what is included in general liability

insurance versus PLI for physicians and other professional staff. We also stated that if data sources were available, we would instruct the contractor to gather the data so we will be ready to implement revised malpractice RVUs for the TC of these codes in conjunction with the update of malpractice RVUs for the PCs in CY 2010.

2.26

1.50

In the CY 2009 PFS final rule (73 FR 69741), we again responded to comments on this issue. We noted that one commenter provided us with the name of a company that provides liability insurance to imaging facilities. We stated that we planned to share the information with our contractor and that if premium data could be identified; it would be incorporated into the malpractice RVU update. Our contractor, Acumen LLC, contacted the company suggested by the commenter and obtained medical physicist malpractice premium data from one of the largest association program insurance brokers and administrators in the United States providing this type of malpractice insurance. The premium data indicate that medical physicists have very low malpractice premiums relative to physicians.

Medical physicists are involved in complex services such as Intensity-Modulated Radiation Therapy (IMRT). IMRT is an advanced mode of radiotherapy that utilizes computer-controlled x-ray accelerators to deliver radiation doses to a malignant tumor. Based on the complexity of these services, we believe that medical

physicists would pay one of the highest malpractice premium rates of the entities furnishing TC services and that using their data as a proxy (in the absence of actual premium data) to develop malpractice RVUs for TC services would be more realistic than our current approach for these entities. Moreover, we believe it is unlikely that actual malpractice premium rates for these entities would exceed those for medical physicists. Therefore, based on this new data collection, we are proposing to use the medical physicists' premium data as a proxy for the malpractice premiums paid by entities providing TC services. We believe that the use of this data will better reflect the level of malpractice premiums paid by entities providing TC services than the current charge-based malpractice RVUs or crosswalks to the malpractice premium data of physician specialties.

As we have done in the past, we continue to encourage public commenters to submit or identify alternative data that we might use for the purpose of establishing malpractice RVUs.

(4) Calculate malpractice RVUs for each code. Resource-based malpractice RVUs were calculated for each procedure. The first step was to identify the percentage of services furnished by each specialty for each respective procedure code. This percentage was then multiplied by each respective specialty's risk factor as calculated in Step 3. The products for all specialties for the procedure were then added together, yielding a specialty-weighted malpractice RVU reflecting the weighted malpractice costs across all specialties for that procedure. This sum was then multiplied by the procedure's work RVUs to account for differences in riskof-service.

Certain codes have no physician work RVUs. The overwhelming majority of these codes are the TCs of diagnostic tests, such as x-rays and cardiac catheterization, which have a distinctly separate TC (the taking of an x-ray by a technician) and PC (the interpretation of the x-ray by a physician). Examples of other codes with no work RVUs are audiology tests and injections. These services are usually furnished by NPPs, in this example, audiologists and nurses, respectively. In many cases, the NPP or entity furnishing the TC is distinct and separate from the physician ordering and interpreting the test. We believe it is appropriate for the malpractice RVUs assigned to TCs to be based on the malpractice costs of the NPP or entity, not the professional liability of the physician.

Our proposed methodology, however, would result in zero malpractice RVUs for codes with no physician work, since we propose the use of physician work RVUs to adjust for risk-of-service. We believe that zero malpractice RVUs for reasons other than rounding would be inappropriate because NPPs and entities such as IDTFs also have malpractice liability.

Note that the earlier discussion above in "(3) Calculate a risk factor for each specialty" addressed the proposed use of the medical physicist premium data to develop a TC risk factor. This TC risk factor is used in (3), as noted above, along with the global risk factor to calculate a PC risk factor. Once the global and PC risk factors are calculated, they are used here in step (4) to calculate the global and PC malpractice RVUs. Once we have calculated the global and PC malpractice RVUs, we propose to address the lack of work RVUs for TC services by setting the TC malpractice RVUs equal to the difference between the global malpractice RVUs and PC malpractice RVUs.

(5) Rescale for budget neutrality. The statute requires that changes to fee schedule RVUs be budget neutral. The current resource-based malpractice RVUs and the proposed resource-based malpractice RVUs were constructed using entirely different malpractice premium data. Thus, the last step is to adjust for budget neutrality by rescaling the proposed malpractice RVUs so that the total proposed resource-based malpractice RVUs equal the total current resource-based malpractice RVUs.

We are requesting comments on our proposed methodology for updating the malpractice RVUs. We are especially interested in comments on our proposed process for revising the malpractice RVUs of the TC of codes with no physician work. Additionally, we intend to post the Acumen report, "Interim Report on Malpractice RVUs for the CY 2010 Medicare Physician Fee Schedule Proposed Rule" on the CMS Web site in conjunction with publication of this proposed.

D. Medicare Telehealth Services

1. Requests for Adding Services to the List of Medicare Telehealth Services

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. In addition, the statute requires us to establish a process for adding services to or deleting services

from the list of telehealth services on an annual basis.

In the December 31, 2002 Federal Register (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

• Category #1: Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.

• Category #2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face "hands on" delivery of the same service. Requesters should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Since establishing the process, we have added the following to the list of Medicare telehealth services: Psychiatric diagnostic interview examination; ESRD services with two to three visits per month and four or more visits per month (although we require at least one visit a month to be furnished in-person "hands on," by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) to examine the vascular access site); individual medical nutrition therapy; neurobehavioral status exam; and follow-up inpatient telehealth consultations.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2008 are considered for the CY 2010 proposed rule. Each request for adding a service to the list of Medicare telehealth

services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requesters should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at http://www.cms.hhs.gov/telehealth/.

2. Submitted Requests for Addition to the List of Telehealth Services

We received requests in CY 2008 to add the following services as Medicare telehealth services effective for CY 2010: (1) Health and behavior assessment and intervention (HBAI) procedures; and (2) nursing facility services. In addition, we received a number of requests to add services that we considered previously and did not approve as Medicare telehealth services in previous PFS rules. These requested services include critical care services; initial and subsequent hospital care; group medical nutrition therapy; diabetes selfmanagement training; speech and language pathology services; and physical and occupational therapy services. The following is a discussion of these requests.

a. Health and Behavior Assessment and Intervention (HBAI)

The American Psychological Association (APA) submitted a request to add HBAI services (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services. The APA asks us to evaluate and approve HBAI services as Category #1 service because they are comparable to the psychotherapy services currently approved for telehealth.

CMS Review

To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and the existing telehealth services in the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter.

Clinical psychologists furnish HBAI services to beneficiaries to help them manage or improve their behavior in response to physical problems. Elements of HBAI services typically include interviewing, observing, and counseling beneficiaries to help them modify their behavior. These elements are also common to the office psychiatry

services currently approved for telehealth. We believe the interaction between a practitioner and a beneficiary receiving individual HBAI services (as described by HCPCS codes 96150 through 96152) is similar to the assessment and counseling elements of the individual office psychiatry services currently approved for telehealth. Therefore, we are proposing to revise § 410.78 and § 414.65 to include individual HBAI services as Medicare telehealth services.

With regard to group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154), we note that no group services are currently approved as Medicare telehealth services. Group counseling services have a different interactive dynamic between the physician or practitioner and his or her patients as compared to individual services. No other group counseling or other group services are approved as telehealth services. Since the interactive dynamic for group HBAI services is not similar to that for individual HBAI services or any other approved telehealth services, we do not believe that group HBAI or family-with-patient HBAI services are properly considered as Category #1 requests. To be considered as a Category #1 request, a service must be similar to the current list of Medicare telehealth services. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743).

Since the interactive dynamic between practitioner and patient for group HBAI and family-with-patient HBAI is not similar to that for office psychiatry services or any other service currently approved for telehealth, we believe that group HBAI and familywith-patient HBAI must be evaluated as Category #2 services. Because we consider group HBAI and family-withpatient HBAI to be Category #2 services, we need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requester did not submit evidence suggesting that the use of a telecommunications system to deliver these services would produce similar diagnostic findings or therapeutic interventions as compared to the faceto-face delivery of these services. As such, we do not propose to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved telehealth services.

b. Nursing Facility Services

In 2005, we received a request to add the following nursing facility services to the list of approved telehealth services:

Initial nursing facility care (as described by HCPCS codes 99304 through 99306); subsequent nursing facility care (HCPCS codes 99307 through 99310); nursing facility discharge services (HCPCS codes 99315 and 99316); and other nursing facility services (HCPCS code 99318). In the CY 2007 PFS final rule with comment period, we did not add these nursing facility care services to the list of approved telehealth services because these procedure codes did not describe services that were appropriate to add to the list of available telehealth originating sites in CY 2007. At that time, skilled nursing facilities (SNFs) were not defined in the statute as originating sites (71 FR 69657)

However, section 149 of the MIPPA added SNFs as telehealth originating sites effective for services furnished on or after January 1, 2009. In light of this provision, the American Telemedicine Association (ATA) urged us to add nursing facility care codes to the list of telehealth services for CY 2009, as

requested in 2005.

In the CY 2009 PFS final rule with comment period, we noted that section 149 of the MIPPA did not add any services to the list of Medicare telehealth services. In the CY 2009 PFS final rule with comment period, we also responded to the ATA's comment suggesting that we add nursing facility care codes to the list of telehealth services for CY 2009, as requested in 2005. In our response, we noted that when we received the 2005 request to consider the addition of nursing facility care services for telehealth for CY 2007, we did not include a full review of these codes in either the CY 2007 PFS proposed rule or final rule with comment period since we believed it was not relevant to add the nursing facility services codes when the SNFs in which these services would be furnished were not eligible originating sites. In the CY 2009 PFS final rule with comment period, we responded that we believe it would be more appropriate to consider the addition of nursing facility care services for telehealth through our existing process, including full notice and comment procedures. We committed to revisiting the 2005 request to add the nursing facility codes in the CY 2010 PFS proposed rule, and we noted that we would accept additional information in support of the 2005 request if we received the information prior to December 31, 2008 (73 FR 69747).

Subsequent to publication of the CY 2009 PFS final rule with comment period, the ATA submitted an amended request to add subsequent nursing facility care; nursing facility discharge

services; and other nursing facility services to the list of approved telehealth services. The Center for Telehealth and e-Health Law submitted a request to add the same nursing facility services and indicated its support of ATA's request. We also received a request from the Marshfield Clinic to add the same services requested by the ATA, plus the initial nursing facility care services. The requesters drew analogies to the evaluation and management (E/M) services currently approved for telehealth, and they provided evidence in support of their belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

CMS Review

The procedure codes included in these requests are used to report E/M services furnished onsite to patients in nursing facilities. In the context of these codes, "nursing facility" describes SNFs, NFs, intermediate care facilities, and psychiatric residential treatment centers.

Medicare telehealth services can only be furnished to beneficiaries located at an originating site authorized by law. A SNF (as defined in section 1819(a) of the Act) is the only type of nursing facility that can also be considered an originating site for telehealth services. Therefore, our review of these services focuses on the potential impact of adding these services when furnished via telehealth to a Medicare beneficiary located in a SNF.

Federally-Mandated Visits in Skilled Nursing Facilities

In describing our assessment, we first describe the service requirements of a Medicare SNF stay. In response to concerns about inadequate care provided to residents of nursing homes, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203) included extensive revisions to the requirements for Medicare and Medicaid certified nursing homes. These provisions were designed to significantly improve the quality of life and the quality of care provided to residents of nursing homes, and were a high priority for the Department of Health and Human Services.

Specific requirements for assuring the quality of care that SNFs must meet to participate in Medicare are specified in section 1819 of the Act. In addition, section 1819(d)(4)(B) of the Act provides that "[a] skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical

facilities thereof as the Secretary may find necessary." The provisions of 42 CFR Part 483 codify the requirements set forth in the statute that long term care facilities are obligated to meet in order to participate in the Medicare and/or Medicaid program.

Section 1819(b)(6)(A) of the Act requires that the medical care of every SNF resident must be provided under the supervision of a physician. The requirements contained in § 483.40 include a prescribed visit schedule and specify that the physician must perform the initial visit personally. Section 483.40(c) requires that the resident of a SNF must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. As we indicated in the preamble to the February 2, 1989 final rule (54 FR 5341), and again in response to comments in the September 26, 1991 final rule (56 FR 48826), the wording of the regulation states that the resident "must be seen" by the physician and requires an actual, faceto-face contact. Except for certain stated exceptions, all required physician visits must be made personally by the physician. Section 483.40(e)(2) requires that when personal performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. Section 483.40(c)(4) requires that the physician must perform the initial visit personally, and § 483.40(c)(5), allows the physician the option of alternating with a qualified NPP (that is, physician assistant, nurse practitioner, or clinical nurse specialist) in making the subsequent required visits. These regulations ensure that at least a minimal degree of personal contact between physician or qualified NPP and resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay (54 FR 5342).

In the CY 2009 PFS final rule with comment period (73 FR 69747), we noted that in considering nursing facility care for telehealth, we would need to carefully evaluate the use of telehealth for the personal visits that are currently required under § 483.40. The OBRA '87 and other long-term care legislation enacted since then require a SNF to care for its residents "in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident" as specified in section 1819(b)(1)(A) of the Act. We believe that a minimum number of periodic, comprehensive, hands-on examinations of a resident by a physician or a qualified NPP are necessary to ensure

that the resident receives quality care. We believe that the complexity of care required by many residents of SNFs warrants at least a minimal degree of direct personal contact between physicians or qualified NPPs and SNF residents. Therefore, we believe that these Federally-mandated visits should be conducted in-person, and not as telehealth services, in order to provide direct personal contact between the resident and the physician or qualified NPP.

In the MMA, the Congress recognized the importance of furnishing the Federally-mandated visits in person, rather than via telehealth. Section 418 of the MMA required the Secretary to submit a Report to Congress evaluating the use of telehealth in SNFs. If the Secretary determined that it was advisable to permit a SNF to be an originating site for telehealth services, the MMA provided the Secretary with the authority to expand telehealth originating sites to include SNFs. SNFs were permitted to be added as originating sites only if the Secretary could establish a mechanism to ensure that telehealth does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner, or clinical nurse specialist.

On November 9, 2007, the Secretary provided to Congress the report specified under section 418 of the MMA, entitled, "Permitting Skilled Nursing Facilities to be Originating Telehealth Sites." Overall, the Report noted that evidence concerning the net impact of allowing SNFs to be originating telehealth sites was not conclusive and further analysis was needed. With respect to Federallymandated visits in SNFs, the Report stated that the Secretary could use its authority to add services to and delete services from the list of Medicare telehealth services as a mechanism to ensure that Federally-mandated visits are not furnished as a Medicare telehealth service by not adding these visits to the lists of Medicare telehealth

In consideration of the history of the OBRA '87, 42 CFR part 483, and Congressional concern expressed in section 418 of the MMA, we do not propose to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We are proposing to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c).

In the following sections, we will separately review the use of telehealth for each of the subcategories of nursing facility services included in these requests. In these discussions, we will also indicate which of these subcategories are used to describe E/M services that fulfill Federal requirements for personal visits under § 483.40.

Initial Nursing Facility Care

The initial nursing facility care procedure codes (as described by HCPCS codes 99304 through 99306) are used to report the initial E/M visit in a SNF or NF that fulfills Federallymandated requirements under § 483.40(c). For survey and certification requirements, this initial visit must occur no later than 30 days after admission. In a SNF, a physician must furnish the initial visit.

One of the requesters noted that once the patient is transferred to the SNF, it might be days until a physician can see a resident in-person. The requester believes a higher quality of care would be provided if the initial nursing facility service can be done in an expeditious manner—via telehealth—rather than delayed until the physician is on site.

As noted above, we are not proposing to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We believe that these Federally-mandated visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Further, we believe it is particularly important that the Federally-mandated initial visit should be conducted in-person because this will ensure that the physician can comprehensively assess the resident's condition upon admission to the SNF through a thorough hands-on examination. We believe that even if the initial visit is delayed for a few days, it is necessary for the resident of a SNF to have a face-to-face visit with the physician who is developing a plan of care. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the initial visit in a face-to-face encounter, and not via telehealth, is necessary to assure quality care. As such, we are not proposing to add the initial nursing facility care services (as described by HCPCS codes 99304 through 99306) to the list of approved telehealth services.

Subsequent Nursing Facility Care

The subsequent nursing facility care procedure codes (as described by HCPCS codes 99307 through 99310) are used to report either a Federallymandated periodic visit under § 483.40(c), or any E/M visit, prior to and after the initial physician visit, that is reasonable and medically necessary to meet the medical needs of the individual resident.

The long-term care regulations at § 483.40 require periodic physician visits for residents of SNFs (and NFs) at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. After the initial visit, Federally-mandated periodic visits in SNFs may, at the option of the physician, alternate between personal visits by the physician and visits by a qualified NPP (who is under the supervision of a physician, and meets the other requirements specified at § 483.40(e)). As noted above, we are not proposing to allow the use of telehealth to furnish these Federally-mandated personal visits. We believe that these Federally-mandated periodic visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the periodic personal visits in face-to-face encounters, and not via telehealth, is necessary to assure quality care.

We considered the possibility of approving subsequent nursing facility care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits. In past years, we did not add hospital E/M visits to the list of Medicare approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (See 69 FR 47511, 69 FR 66276, 72 FR 38144, 72 FR 66250, 73 FR 38517, and 73 FR 69745.) Many residents of SNFs require medically complex care, and we have similar concerns about allowing physicians or NPPs to furnish E/M visits via telehealth to residents of SNFs.

Because the complexity of care required by many residents of SNFs may be significantly greater than the complexity of care generally associated with patients receiving the office visits approved for telehealth, we do not consider E/M visits furnished to residents of SNFs similar to the office visits on the current list of Medicare telehealth services. Therefore, we believe the use of subsequent nursing facility care for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits must be evaluated as a Category #2 service.

Because we consider subsequent nursing facility care to be a Category #2 request, we evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requesters submitted supporting documentation intended to suggest that the use of telehealth could be a reasonable surrogate for the face-toface delivery of this type of care.

One study assessed the impact of videoconferencing (as opposed to communication by telephone without video) on nighttime, on-call medical decision-making in the nursing home. The comparison of videoconferencing with telephonic communication of information by nurses does not provide a comparative analysis demonstrating that E/M visits furnished via telehealth to residents of SNFs is equivalent to the face-to-face delivery of such services. As such, this study was not relevant to this review.

Another study assessed the value of a monitoring system in reducing falls and injuries in non-acute late-evening and nighttime situations in a nursing home setting. The monitoring system described in this study was comprised of sensors to alert caregivers via a silent pager when a high-risk resident exits his or her bed, bedroom, or bathroom. This allows caregivers to aid the resident and potentially reduce falls. The technologies utilized in this study do not correspond with our definitions of telehealth as specified in § 410.78. In addition, this type of resident monitoring is performed typically by nursing staff and is not an E/M visit. As such, this study was not relevant to this review.

A third study presented the savings achieved through avoiding transport to emergency departments and physicians' offices by furnishing visits via telehealth to residents in nursing facilities. The study did not provide any comparative analysis of the services furnished via telehealth with those furnished in person.

A fourth study evaluated the impact of telemedicine as a decision aid for residents of long-term care SNFs with chronic wounds. The patients selected for this study were alert and intellectually interactive. The study concluded that furnishing a telehealth consultation prior to a face-to-face consultation increased the level of patient comfort with care-related decisions made during the face-to-face consultation. The control group did not receive an equivalent intermediate consultation face-to-face that could be compared to the services furnished to the test group. We acknowledge the study's findings that the intermediate telehealth consultation was a useful decision aid, but we do not consider this a comparative analysis between delivery of the same type of care via telehealth versus face-to-face.

We received a pilot study evaluating the usefulness of E/M services furnished via telehealth for making routine medical decisions in the nursing home. The nursing home residents were evaluated over videoconferencing and then evaluated immediately afterward by the same clinician in person. On a scale of 1 to 5 (1 being the least ill), the clinicians assessed the illness level of these residents at 3 or below, with the illness level for over 65 percent of the encounters assessed at "1." Videoconferencing without a face-toface examination was sufficient for making medical decisions in most cases studied in this pilot, although face-toface examinations were preferred. Clinicians generated orders in 30 percent of these paired encounters, with a predominance of orders generated after, rather than before, the face-to-face examination. The study also noted that even when nursing home residents were alert, they had limited participation in the telemedicine interactions and were not as involved in making informed medical decisions with their clinicians, compared to face-to-face encounters. The study suggests that remote examination by video might serve as a substitute for some routine visits, if interspersed with face-to-face examinations. The study concluded that videoconferencing is feasible for making routine medical decisions in the nursing

We appreciate the comparative analysis provided by this study. However, we note that this study focused on the usefulness of telehealth for routine decision-making in the nursing home, and the reported illness levels of the residents in these sample encounters was relatively low to moderate. We do not consider these findings persuasive that telehealth can, more generally, be an adequate substitute for the face-to-face delivery of E/M visits to residents of SNFs who might require more medically complex care.

We considered the possibility of approving the use of telehealth to furnish E/M visits to residents of SNFs who do not require medically complex care or approving subsequent nursing facility care for telehealth only for medically necessary E/M visits with straightforward or low complexity medical decision-making (as described by HCPCS codes 99307 and 99308). Although this last pilot study concluded that videoconferencing is feasible for making routine medical decisions in the nursing home, we are concerned with the study's finding that residents with low to moderate levels of reported illness had limited participation in the telemedicine interactions and less involvement in making informed medical decisions with their clinicians, compared to face-to-face encounters. Under section 1819(c)(1)(A) of the Act, a SNF must protect and promote the rights of each resident, including the right to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care or treatment. Under $\S 483.10(b)(3)$, a resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. If the use of telehealth does not elicit from residents with low to moderate reported illness adequate participation in making informed medical decisions with their clinicians when compared to face-toface encounters, we believe that telehealth is not an adequate substitute for the face-to-face delivery of E/M visits to any residents of SNFs.

After reviewing these studies, we do not have sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. Therefore, we are not proposing to add subsequent nursing facility care services (as described by HCPCS codes 99307 through 99310) to the list of approved telehealth services.

Nursing Facility Discharge Day Management

The nursing facility discharge day management codes (as described by HCPCS codes 99315 and 99316) are used to report an E/M visit that prepares a resident for discharge from a nursing facility. We note that there is no Medicare Part B requirement to furnish

and bill an E/M visit in preparation for a resident's discharge from a SNF. However, if a physician or qualified NPP bills a Nursing Facility Discharge Services code, we believe that a face-toface encounter will better insure that the resident is prepared for discharge, as we do not have evidence that nursing facility discharge services via telehealth is adequately equivalent to face-to-face provision. As such, we are not proposing to add the nursing facility discharge day management services (as described by HCPCS codes 99315 and 99316) to the list of approved telehealth services.

Other Nursing Facility Service

In 2006, CPT added a procedure code for Other Nursing Facility Service (CPT code 99318) to describe an annual nursing facility assessment. An annual assessment is not one of the required visits under the long-term care regulations at § 483.40. For Medicare purposes, this code can be used in lieu of a Subsequent Nursing Facility Care code to report a Federally-mandated periodic personal visit furnished under § 483.40(c). An annual assessment visit billed using CPT code 99318 does not represent a distinct benefit service for Medicare Part B physician services, and it cannot be billed in addition to the required number of Federally-mandated periodic personal visits. Under Medicare Part B, we cover this procedure code if the visit fully meets the CPT code 99318 requirements for an annual nursing facility assessment and if such an annual assessment falls on the 60-day mandated visit cycle. We are not proposing to add the other nursing facility care services (as described by HCPCS code 99318) to the list of approved telehealth services because this code is payable by Medicare only if the visit is substituted for a Federallymandated visit under § 483.40(c). As explained above, we believe all of the Federally-mandated periodic visits must be conducted in person.

Follow-up Inpatient Consultations

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations. In the hospital setting, the AMA advised practitioners to bill for services that would previously have been billed as follow-up inpatient consultations using the procedure codes for subsequent hospital care (as described by CPT codes 99231 through 99233). In the nursing facility setting,

the AMA advised practitioners to bill for these services using the procedure codes for subsequent nursing facility care (as described by CPT codes 99307 through 99310).

In the CY 2008 PFS proposed rule (72 FR 38144) and subsequent final rule with comment period (72 FR 66250), we discussed a request from the ATA to add subsequent hospital care to the list of approved telehealth services. Because there was no method for practitioners to bill for follow-up consultations delivered via telehealth to hospital inpatients, the ATA requested that we add the subsequent hospital care codes to the list of Medicare approved telehealth services. We expressed our concern that subsequent hospital care codes describe a broader range of services than follow-up consultations, including some services that may not be appropriate to be furnished via telehealth. We committed to continue evaluating the issues.

In the CY 2009 PFS proposed rule (73 FR 38517), we proposed to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. In the CY 2009 PFS final rule with comment period (73 FR 69745), we finalized our proposal to create follow-up inpatient telehealth consultation codes (as described by HCPCS codes G0406 through G0408) and added these Gcodes to the list of Medicare telehealth services. These HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth. (See the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.3.1 for the current definition of follow-up inpatient telehealth consultations.)

We note that if the former codes for follow-up consultations (as described by CPT codes 99261 through 99263) still existed, these procedure codes would also be available to practitioners to submit claims to their Medicare contractors for payment of follow-up consultations provided via telehealth to patients located in SNFs. Although we did not receive a public request to add follow-up inpatient consultations for patients in SNFs to the list of approved Medicare telehealth services, we recognize a similar need to establish a method for practitioners to furnish and bill for follow-up consultations delivered via telehealth to patients in SNFs.

We considered the possibility of approving subsequent nursing facility

care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for follow-up consultations. However, as discussed above, we do not believe it would be appropriate for E/M visits to be furnished via telehealth to treat residents of SNFs requiring medically complex care. We are concerned that it could be difficult to implement sufficient controls and monitoring to ensure that the use of the subsequent nursing facility care codes for telehealth is limited to the delivery of services that were formerly described as follow-up inpatient consultations.

We considered creating new G-codes to enable practitioners to bill for the services that were formerly described as follow-up inpatient telehealth consultations when furnished to residents of SNFs. We examined the feasibility of creating such codes to parallel the subsequent nursing facility care services, which are the codes currently used to bill these follow-up consultations in a face-to-face encounter. We found that the elements of the four levels of subsequent nursing facility care did not correspond to the three levels of the deleted CPT codes previously used for follow-up inpatient consultations. We believe that it would be administratively simpler to utilize the three existing codes for follow-up inpatient telehealth consultations rather than add additional G-codes. The use of the same "follow-up inpatient telehealth consultation" G-codes for services furnished in both hospital inpatient and SNF settings would also correspond to the use of the previous CPT codes for services furnished to hospital inpatients and residents of SNFs.

For CY 2010, we are proposing to revise § 410.78 to specify that the Gcodes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs. The HCPCS codes will clearly designate these services as follow-up consultations provided via telehealth, and not subsequent nursing facility care used for E/M visits. Utilization of these codes for patients in SNFs will facilitate payment for these services, as well as enable us to monitor whether the codes are used appropriately.

As described in the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 190.3.1, follow-up inpatient telehealth consultations

include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation and is not appropriate for delivery via telehealth.

Consistent with our policy for followup telehealth consultations furnished to hospital inpatients, in order to bill and receive payment for these services, physicians and practitioners must submit the appropriate HCPCS procedure code for follow-up inpatient telehealth consultations along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with the follow-up inpatient telehealth consultation codes, the distant site physician or practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.6.1 for instructions for submission of interactive telehealth claims.)

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the "GQ" modifier, "via asynchronous telecommunications system." By using the "GQ" modifier, the distant site physician or practitioner certifies that the asynchronous medical file was collected and transmitted to him or her at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 190.6.2 for instructions for submission of telehealth store and forward claims.)

c. Critical Care Services

In the CY 2009 PFS proposed rule (73 FR 38517), we reviewed a request submitted by the University of Pittsburgh Medical Center (UPMC) to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. UPMC drew analogies to the E/M consultation services currently approved for telehealth and described how it uses telehealth to give stroke patients timely access to consultative input from highly specialized physicians who are not available to furnish services face-to-face.

In the CY 2009 PFS final rule with comment period (73 FR 69744), we did not add critical care services to the list of approved telehealth services. This request was not considered as a category #1 request because, as we stated, we believe that remote critical care services are a different service than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). We stated that we had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care, and we did not add critical care services to the list of Medicare approved telehealth services. We noted that this decision does not preclude physicians from providing telehealth consultations to critically ill patients.

Following publication of the CY 2009 PFS final rule with comment period, Philips Healthcare, the maker of a remote critical care system, submitted an expanded request to add critical care services to the list of Medicare approved telehealth services. The Philips Healthcare request stated that critical care services can be approved as a Category #1 service based on their similarity to the inpatient consultation services currently approved for telehealth. The requester noted that many of the components of critical care are similar to a high-level inpatient consultation service, which is currently approved for telehealth. Common components include obtaining a patient history, conducting an examination, and engaging in complex medical decisionmaking for patients who may be severely ill. Because we classified critical care as a Category #2 service last year, Philips also submitted evidence to support its belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

CMS Review

To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. In this case, we look for such similarities between critical care and inpatient consultations and other similar services on the current list of approved Medicare telehealth services. Critical care (as described by HCPCS codes 99291 and 99292) is the direct delivery by a physician of medical care for a critically ill or critically injured patient. It involves high complexity decision-making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/ or to prevent further life-threatening deterioration of the patient's condition. Within the current standards of practice, we believe critical care services require the physical presence of the physician rendering the critical care services. We also note that a number of hands-on interventions (for example, gastric intubation and vascular access procedures), when furnished on the day a physician bills for critical care, are included in the critical care service and are not reported separately. Inpatient consultations generally do not include hands-on interventions. Because we believe that critical care services (as described by HCPCS codes 99291 and 99292) require the physical presence of a physician who is available to furnish any necessary hands-on interventions, we do not consider critical care services similar to any services on the current list of Medicare telehealth services. Therefore, we believe critical care must be evaluated as a Category #2 service.

In order to evaluate critical care services as a Category #2 service, we need to determine whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. In CPT 2009, the AMA defined remote critical care services tracking codes (codes 0188T through 0189T) with cross-references to critical care services (HCPCS codes 99291 through 99292). CPT directs that only one physician may report either critical care services or remote critical care services for the same period. The requester cites this as evidence that the AMA considers the two services equivalent, and that critical care should be approved as a Category #2 service. We do not consider the CPT coding guidance persuasive evidence that

remote critical care is the telehealth delivery of critical care, as defined by HCPCS codes 99291 and 99292. We believe that if the AMA valued the two services equally, they would not have created separate tracking codes for remote critical care services.

As we noted in the CY 2009 PFS final rule with comment period, consistent with the AMA's creation of tracking codes, we believe that remote critical care services are different from the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Category III CPT codes track utilization of a service, facilitating data collection on, and assessment of, new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

The requester also submitted studies which conclude that remote critical care services furnished by intensivists improve mortality rates, decrease length of stay, reduce per patient costs, and improve compliance with best practices, thereby improving patient outcomes. These studies are similar to the ones we received and reviewed from the CY 2009 PFS proposed rule. We maintain that remote critical care services are not the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Therefore, we do not find the new studies submitted with the CY 2010 request persuasive that telehealth can be an adequate substitute for the face-to-face delivery of critical care services (as described by HCPCS codes 99291 and 99292).

We continue to believe that remote critical care services are different services than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). As such, we are not proposing to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. We reiterate that our decision not to add critical care services to the list of approved telehealth services does not preclude physicians from furnishing telehealth consultations to critically ill patients.

d. Other Requests

We received a number of requests to add services that we reviewed and did not approve in previous PFS Rules. The following are brief summaries and references to previous discussions regarding our decisions not to add these procedure codes to the list of Medicare approved telehealth services. As explained further below, we are not reconsidering these previous decisions.

Initial and Subsequent Hospital Care

We received a request to add initial hospital care (as described by HCPCS codes 99221 through 99223) and subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved telehealth services. In response to previous requests, we did not add initial or subsequent hospital care to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a highacuity hospital inpatient. (See 69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are not proposing to add initial hospital care (as described by HCPCS codes 99221 through 99223) or subsequent hospital care (as described by HCPCS) codes 99231 through 99233) to the list of approved telehealth services.

Group Medical Nutrition Therapy Services

We received a request to add group medical nutrition therapy (MNT) services (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services. In response to a previous request, we did not add group MNT to the list of approved telehealth services because we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157.) We did not receive any new information with this request that would alter our previous decision. Therefore, we are not proposing to add group MNT (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services.

Diabetes Self-Management Training (DSMT)

We received a request to add diabetes self-management training (DSMT) (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services. In response to previous requests, we did not add DSMT to the list of approved telehealth services because of the statutory requirement that DSMT include teaching beneficiaries to self-administer injectable drugs. Furthermore, DSMT is often performed in group settings and we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are

not proposing to add DSMT (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services

Speech and Language Pathology Services

We received a request to add various speech and language pathology services to the list of approved telehealth services. Speech-language pathologists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we do not propose to add any speech and language pathology services to the list of Medicare telehealth services. (For further discussion, see 69 FR 47512 and 66276, and 71 FR 48995 and 69657.)

Physical and Occupational Therapy Services

We received a request to add various physical and occupational therapy services to the list of approved telehealth services. Physical and occupational therapists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we are not proposing to add any physical and occupational therapy services to the list of approved telehealth services. (For further discussion, see 71 FR 48995 and 69657.)

E. Coding Issues

1. Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP). This procedure is a treatment for vertigo which involves therapeutic maneuvering of the patient's body and head in order to use the force of gravity to redeposit the calcium crystal debris in the semicircular canal system.

In the CY 2009 PFS final rule with comment period (73 FR 69896), new CPT code 95992, Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day, was assigned the bundled status indicator (B). We explained that this procedure previously was billed as part of an evaluation and management (E/M) service or under a number of CPT codes, including CPT code 97112, Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. We also explained that because neurologists and therapists are the predominant providers of this service to Medicare patients (each at 22 percent), it was assigned as a

"sometimes therapy" service under the therapy code abstract file.

We received comments on this issue from the American Physical Therapy Association (APTA), as well as other organizations expressing opposition to our decision to bundle the new code. Commenters stated that they believe that our decision to bundle CPT code 95992 is flawed since physical therapists are unable to bill E/M services. The commenter also stated that therapists would be precluded from using another code for billing for this service because CPT correct coding instructions require that the provider/ supplier select the procedure that most accurately defines the service provided. Commenters also expressed concern that this could impact beneficiary access to this service.

Based upon the commenters' feedback, we realized that we had failed to address how therapists would bill for the service since they cannot bill E/M services. In order to address this situation so that access to this service would not be impacted, we included language in a change request (CR) (the quarterly update CR for April) and also released a MedLearn article informing PTs to continue using one of the more generally defined "always therapy" CPT codes (97112) as a temporary measure. See http://www.cms.hhs.gov/ transmittals/downloads/R1691CP.pdf and http://www.cms.hhs.gov/ MLNMattersArticles/downloads/ MM6397.pdf.

In response to the concerns raised and upon additional review of this issue for CY 2010, we are proposing to change the status indicator from B (Bundled) to I (Invalid). We propose that physicians would continue to be paid for CRP as a part of an E/M service. Physical therapists would continue to use one of the more generally defined "always therapy" CPT codes (97112). We believe that this will enable beneficiaries to continue to receive this service while at the same time it will address our concerns about the potential for duplicate billing for this service to the extent that this service is paid as a part of an E/M service. As a result of this proposal, CPT code 95992 would be removed as a "sometimes" therapy code from the therapy code list.

2. Payment for an Initial Preventive Physical Examination (IPPE)

Beginning January 1, 2010, we propose to increase the payment for an initial preventive physical examination (IPPE) furnished face-to-face with the patient and billed with HCPCS code G0402, *Initial preventive physical examination; face-to-face visit, services*

limited to new beneficiary during the first 12 months of Medicare enrollment. The IPPE service includes a broad array of components and focuses on primary care, health promotion, and disease prevention.

Section 101(b) of the MIPPA changed the IPPE benefit by adding to the IPPE visit the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning. Section 101(b) of the MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of the IPPE.

In order to implement this MIPPA provision, in the CY 2009 PFS final rule with comment period (73 FR 69870), we created HCPCS code G0402 as a new HCPCS code and retained, on an interim basis, the work RVUs of 1.34 assigned to HCPCS code G0344, the code that was previously used to bill for the IPPE. While we did not believe the revisions to the IPPE required by MIPPA impacted the work RVUs associated with this service, we solicited public comments on this issue, as well as suggested valuations of this service to reflect resources involved in furnishing the service.

We received comments from several medical groups representing primary care physicians and geriatricians, as well as comments from the American Medical Association concerning this issue. The commenters stated that the IPPE service was undervalued prior to the addition of components by the MIPPA. Commenters also stated that the current level of work RVUs would discourage delivery of appropriate endof-life planning with the beneficiary. One commenter suggested the work associated with HCPCS code G0402 for the IPPE, as described in statute, is captured in existing CPT code 99387, Preventive Medicine Service, new patient, Initial comprehensive preventive medicine, 65 years and older. (This code is not paid under the PFS.) The work RVUs for this CPT code are

Based on a review of the comments and upon further evaluation of the component services of the IPPE, we believe the services, in the context of work and intensity, contained in HCPCS code G0402 are most equivalent to those services contained in CPT code 99204, Evaluation and management new patient, office or other outpatient visit, and propose increasing the work RVUs for HCPCS code G0402 to 2.30 effective for services furnished beginning on January 1, 2010.

3. Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule with comment period (73 FR 69890), we noted that the RUC reviewed and recommended work RVUs for 6 audiology codes with which we agreed (that is, CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). We also noted that in the Medicare program, audiology services are provided under the diagnostic test benefit and that some of the work descriptors for these services include "counseling," ''potential for remediation,'' and "establishment of interventional goals." We noted that we do not believe these aspects fit within the diagnostic test benefit, and therefore, we solicited comment on this issue.

Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists. This distinction is of particular importance since CPT codes 92620, 92621, 92626, 92627, and 92640 are "timed" codes, that is, these codes are billed based on the actual time spent furnishing the service. In response to our request, the society that represents speech language pathologists, audiologists, and speech and language scientists, provided the following comments.

Comment: With respect to the term "counseling," the commenter stated that "counseling" as used in the intraservice work description for CPT code 92640, Diagnostic analysis with programming of auditory brainstem implant, per hour, is used in the context of informational rather than personal counseling. In this instance the counseling provides information and guidance to the patient on what to expect relative to the service (application of the electrical stimulation). This counseling is an integral part of the diagnostic procedure and not a means of providing therapy or active treatment.

Response: We appreciate the comments related to counseling by the specialty society, but are not persuaded that counseling is an integral part of a diagnostic test. Although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, counseling the patient about how to compensate for a hearing loss is part of a therapeutic service. As such, therapeutic and/or management of disease process counseling are not part of the diagnostic test benefit and time attributable to such activities is not payable to audiologists under the Medicare program.

Comment: With respect to the term 'potential for remediation," which is found as part of the intraservice work descriptor for CPT code 92625, Assessment of tinnitus (includes pitch, loudness matching, and masking), the commenter states that the procedure evaluates the frequency and intensity characteristics of the perceived tinnitus in addition to measuring how the tinnitus responds to a masking noise. The response to masking noise is diagnostic information that audiologists and physicians refer to as the "potential for remediation." This assessment is thus a part of a complete diagnostic workup and is not a treatment or therapeutic service.

Response: The intraservice work for this service includes informing the patient of the outcome of the evaluation and the potential for remediation. As noted above, although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, discussing therapeutic options and/or providing therapy or management based on test results are not part of a diagnostic test. Discussing the potential for remediation does not appear to be part of a diagnostic test. While this service can involve a small amount of nondiagnostic work, CPT code 92625 is not a timed code and the bulk of the work described in the code appears to be diagnostic in nature.

Comment: With respect to the term "establishment of interventional goals," this phrase is found in the intraservice work description of CPT code 92626, Evaluation of auditory rehabilitation status; first hour. The commenter states that this procedure focuses on diagnostic information relative to the patient's ability to use residual hearing with a hearing aid, a cochlear implant, or with no electronic device. The intervention goals may take a variety of forms, such as the following: Meeting audiological criteria for cochlear implantation; a recommendation to continue use of hearing aids (that is, not a cochlear implant candidate); and the need to coordinate with a speechlanguage pathologist for auditory training. This provides the physician with a complete diagnostic evaluation of the patient's residual hearing status. There is no element of therapy or treatment associated with this service.

Response: Diagnostic testing usually does not involve the establishment of interventional goals. The test report usually contains test findings and may suggest additional tests. While we appreciate the comments of the specialty society, we are not persuaded that establishing interventional goals is

part of a diagnostic test under Medicare. The establishment of interventional goals is clearly a function of therapeutic management. As such, establishment of goals is not part of the diagnostic test benefit and time attributable to such activity is not payable to an audiologist under the Medicare program.

We appreciate the comments we received on this issue. We want to emphasize that therapeutic and/or management activities associated with these audiology tests are not payable to audiologists because of the benefit category under which these tests are covered. We may also issue instructions to contractors to monitor these services to prevent inappropriate payments.

4. Consultation Services

a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, § 30.6.10A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, § 30.6.10B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at § 30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Ådditional manual revisions in both January and September 2001 (at § 30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (http:// www.cms.hhs.gov/MLNEdWebGuide/ 25 EMDOC.asp) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, "Consultations in Medicare: Coding and Reimbursement" (OEI–09–02–00030). The purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed

approximately \$1.1 billion more in 2001 than it should have for services that were billed as consultations.

Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47 percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below.

continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory

Our consultation policy revisions

consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff, maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at § 30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006 coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation, is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CPT has not clarified transfer of care. Therefore, many physician groups disagree with our

requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition remains ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There is an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Medicare does provide guidance although there is disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is

evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, § 30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Proposal

Beginning January 1, 2010, we propose to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

We note that section 1834(m) of the Act includes "professional consultations" (including the initial inpatient consultation codes "as subsequently modified by the Secretary") in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, if we finalize our proposed policy to eliminate

consultations from the PFS, then we propose to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

If we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we also propose to crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of SNFs and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in § 410.78 and in our manuals as appropriate for use to deliver care to

beneficiaries in hospitals or skilled nursing facilities. If we adopt this proposal, then we will make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we will add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

This proposed change would be implemented in a budget neutral

manner, meaning it would not increase or decrease PFS expenditures. We would make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We have crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. This change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization. The PE and malpractice RVU methodologies are described elsewhere in this proposed rule.

We are soliciting comments on the proposal, described more fully above, to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility.

Additionally, we are soliciting comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.

- F. Potentially Misvalued Services Under the Physician Fee Schedule
- 1. Valuing Services Under the Physician Fee Schedule

The American Medical Association's (AMA) Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued. On an ongoing basis, the AMA RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE relative value units (RVUs).

To address concerns expressed by stakeholders with regard to the process we use to price services paid under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. As we stated in the CY 2009 PFS proposed rule (73 FR 38582), the workgroup identified some potentially misvalued codes through several vehicles, namely, identifying codes with

site of service anomalies, high intraservice work per unit time (IWPUT), and services with high volume growth. The IWPUT is derived from components of the "building-block" approach, as described in the CY 2007 PFS proposed rule (71 FR 37172), and is used as a measure of service intensity. There were 204 services identified as misvalued last year and we plan to continue working with the AMA RUC to identify additional codes that are potentially misvalued. In the CY 2009 PFS proposed rule (73 FR 38586), we also listed approaches for the AMA RUC to utilize, namely, the review of the fastest growing procedure codes, review of Harvard-valued codes, and review of PE RVUs.

We plan to address the AMA RUC's recommendations from the February and April 2009 meetings for codes with site of service anomalies in the CY 2010 PFS final rule with comment period in a manner consistent with the way we address other AMA RUC recommendations. Specifically, we complete our own review of the AMA RUC recommendations; and then in the PFS final rule with comment period, we describe the AMA RUC's recommendations, indicate whether or not we accept them, and provide a rationale for our decision. The values for these services will be published as interim values for the next calendar

We believe that there are additional steps we can take to help address the issue of potentially misvalued services. In the CY 2009 PFS proposed rule, we identified approaches to address this issue including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.

2. High Cost Supplies

In the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update the prices associated with high cost supplies over \$150 every 2 years. We explained that we would need the cooperation of the medical community in obtaining typical prices in the marketplace. We also outlined examples of acceptable documentation. Although we received many thoughtful comments on the proposed process for updating high-cost supplies, as stated in the CY 2009 PFS final rule with comment period (73 FR 69882), we are continuing to examine alternatives on the best way to obtain accurate pricing information and will propose a revised process in future rulemaking.

3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures

In the CY 2009 PFS final rule with comment period (73 FR 69882), we stated that we plan to perform a data analysis of nonsurgical CPT codes that are often billed together. This would identify whether there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services, or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that certain clinical labor activities, supplies, and equipment are not performed or furnished twice when multiple procedures are performed. We stated that we would consider developing a proposal either to bundle additional services or expand application of the MPPR to additional procedures.

Several specialty groups noted that the AMA RUC has already taken action to identify frequently occurring code pairs. The commenters support the AMA RUC's recommendation that CMS analyze data to identify nonsurgical CPT codes that are billed together 90 to 95 percent of the time. Additionally, the Medicare Payment Advisory Committee (MedPAC) requested that we consider duplicative physician work, as well as PE, in any expansion of the MPPR.

We plan to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. We will analyze both physician work and PE inputs. If duplications are found, we will consider whether an MPPR or bundling of services is most appropriate. Any proposed changes will be made through rulemaking and be subject to public comment at a later date.

4. AMA RUC Review of Potentially Misvalued Codes

a. Site of Service Anomalies

The AMA RUC created the Five-Year Review Identification Workgroup to respond to concerns expressed by the MedPAC, the Congress, and other stakeholders regarding accurate pricing under the PFS. The workgroup identified potentially misvalued codes through several vehicles. For example, the workgroup focused on codes for which there have been shifts in the site of service (site of service anomalies), codes with a high intra-service work per unit of time (IWPUT), and codes that were high volume. There were 204 potentially misvalued services

identified in 2008 (see the CY 2009 PFS final rule with comment period (73 FR 69883)). These codes were reviewed by the AMA RUC and recommendations were submitted to CMS in 2008.

In the CY 2009 PFS final rule with comment period (73 FR 69883), we noted that although we would accept the AMA RUC valuation for these site of service anomaly codes for 2009, we recognized that many of them included deletion or modification of certain inputs such as hospital days, office visits, service times, and discharge day management services in the global period. We also indicated that we had concerns about the methodology used by the AMA RUC to review these services which may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. However, we stated that we believed the AMA RUCrecommended valuations were still a better representation of the resources used to furnish these services than the current ones. We also stated that we would continue to examine these codes and would consider whether it would be appropriate to propose additional changes in future rulemaking.

After further review of these codes, we believe it would be appropriate to propose further changes to several of the codes where the valuation has been adjusted to reflect changes in the site of service. Specifically, we are proposing changes to codes for which the AMA RUC review process deleted or reallocated pre-service and post service times, hospital days, office visits, and discharge day management services

without the extraction of the associated RVUs.

We believe the AMA RUCrecommended values do not reflect the extraction of the RVUs associated with deleted or reallocated pre-service and post-service times, hospital days, office visits, and discharge day management services. Therefore, we have recalculated the work RVUs based upon the AMA RUC-recommended inputs (that is, changes in pre-service and postservice times and associated E/M services). The proposed work RVUs for each CPT code shown in Table 8 were recalculated using the pre-AMA RUC review work RVUs as a starting point, and adjusting them for the addition or extraction of pre-service and postservice times, inpatient hospital days, discharge day management services and outpatient visits as recommended by the AMA RUC. We used the following methodology:

- 1. For each CPT code noted in Table 8, we separated out each component (that is, pre-service time, intra-service time, post-service time, inpatient hospital day, discharge day management services, and outpatient visits) that comprised the entire work RVUs for the service.
- 2. We calculated the incremental difference between the pre-service and post-service time from before and after the AMA RUC review, and multiplied that difference by an IWPUT intensity factor of 0.0224, which is a constant in the IWPUT equation. For example, if the pre-service time prior to the AMA RUC review was 75 minutes and, following its review, the AMA RUC recommended an increase in pre-service time to 85 minutes, we multiplied the difference

- (10 minutes) by 0.0224 to determine the RVUs associated with the increase in pre-service time, and then added that number of RVUs to the pre-AMA RUC evaluation work RVU.
- 3. We then added or removed the work RVUs associated with the extraction or reallocation of each inpatient hospital day, outpatient visit or discharge day management service as appropriate. For example, assume that prior to the AMA RUC review a code was assigned:
- 1 inpatient hospital day (currently billed using CPT code 99231 and assigned 0.76 work RVUs);
- 1 discharge day management service (currently billed using CPT code 99238 and assigned 1.28 work RVUs); and
- 2 outpatient visits (currently billed using 99212 and assigned 0.45 work RVUs).

After the AMA RUC review, the inpatient hospital day and discharge day management service were removed. To account for the removal of these services, we would have subtracted 0.76 work RVUs (represents the removal of the work RVUs for 1 inpatient hospital day) and 1.28 work RVUs (represents the removal of the work RVUs for 1 discharge day management service) from the pre-AMA RUC review work RVUs in order to develop the CMS proposed work RVUs.

The methodology discussed above was used for each code noted in Table 8 and reflects the extraction of the RVUs associated with deleted or reallocated hospital days, office visits, discharge day management services, and preservice and post-service times based upon the AMA RUC recommendations.

TARLE 8	·CY	2010	CMS	PROPOSED	WORK	RVUs

CPT code ¹	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC rec- ommended work RVU	2010 CMS proposed work RVU
21025	Excision of bone, lower jaw	11.07	9.87	7.23
23415	Release of shoulder ligament	10.09	9.07	10.64
25116	Remove wrist/forearm lesion	7.38	7.38	4.83
42440	Excise submaxillary gland	7.05	7.05	6.88
52341	Cysto w/ureter stricture tx	6.11	5.35	5.20
52342	Cysto w/up stricture tx	6.61	5.85	5.63
52343	Cysto w/renal stricture tx	7.31	6.55	6.55
52344	Cysto/uretero, stricture tx	7.81	7.05	6.83
52345	Cysto/uretero w/up stricture	8.31	7.55	8.51
52346	Cystouretero w/renal strict	9.34	8.58	9.02
52400	Cystouretero w/congen repr	10.06	8.66	8.25
52500	Revision of bladder neck	9.39	7.99	8.49
52640	Relieve bladder contracture	6.89	4.73	4.28
53445	Insert uro/ves nck sphincter	15.21	15.21	17.02
54410	Remove/replace penis prosth	16.48	15.00	16.01
54530	Removal of testis	9.31	8.35	8.65
57287	Revise/remove sling repair	11.49	10.97	10.36
62263	Epidural lysis mult sessions	6.41	6.41	6.04
62350	Implant spinal canal cath	8.04	6.00	1.29

CPT code ¹	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC rec- ommended work RVU	2010 CMS proposed work RVU
63650	Implant neuroelectrodes	7.57	7.15	4.18
63685	Insrt/redo spine n generator	7.87	6.00	4.27
		6.22	6.22	7.36
64831	Repair of digit nerve	10.23	9.00	9.74
65285	Repair of eye wound	14.43	14.43	14.43

TABLE 8: CY 2010 CMS PROPOSED WORK RVUS—Continued

Using the methodology described above, the adjustments to work RVUs for CPT codes 62355, 62360, 62361, 62362, and 62365 would result in negative valuation: 62355 = -1.96; 62360 = -2.31; 62361 = -2.42; 62362 = -2.46; and 62365 = -1.88. For these codes, we are requesting that the AMA RUC re-review the entire family of associated codes and in the interim will maintain the AMA RUC recommended values until a methodology is developed to address codes that result in negative valuation when the methodology described above is utilized.

In addition to the proposed revisions to the AMA RUC-recommended RVUs described above, we encourage the AMA RUC to utilize the building block methodology as described in the CY 2007 PFS proposed rule (71 FR 37172) in the future when revaluing codes with site of service anomalies. We recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. However, the relative value scale requires each service to be valued based on the resources used in furnishing the service.

We are also seeking public comment on alternative methodologies that could be utilized to establish work RVUs for codes that would have a negative valuation under the methodology we used for the proposed revisions to the AMA RUC-recommended values described above.

b. "23-Hour" Stay

For services that are performed in the outpatient setting and require a hospital stay of less than 24 hours, we consider this an outpatient service and recognize the additional time associated with the patient evaluation and assessment in the post-service period. We are requesting that the AMA RUC include the additional minutes in their recommendations to CMS. We do not believe the current minutes assigned in the post-service period accurately reflects the total time required for evaluation and assessment of the patient. We believe the use of E/M codes

for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre-service and intraservice work that would not be provided. Therefore, we will not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

5. Establishing Appropriate Relative Values for Physician Fee Schedule Services

In MedPAC's March 2006 Report to Congress, MedPAC made a number of recommendations to improve the review of the relative values for PFS services. Since that time, we have taken significant action to improve the accuracy of the RVUs. As MedPAC noted in its recent March 2009 Report to Congress, "CMS and the AMA RUC have taken several steps to improve the review process" in the intervening years since those initial recommendations. Many of our efforts to improve the accuracy of RVUs have also resulted in substantial increases in the payments for primary care services, which was one of the motivations for MedPAC's recommendations.

- We completed the most recent Five-Year Review of work RVUs, resulting in an increase in over 25 percent to the work RVUs for primary care services.
- We significantly revised the methodology for determining PE RVUs, resulting in more than a 5 percent increase for primary care services.
- We improved our processes for identifying potentially misvalued services by engaging in an ongoing review that includes screens for rapidly growing services and services with substantial shifts in site of service. We also identified approaches to address the issue of potentially misvalued services including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional

nonsurgical procedures and the update of high cost supplies.

• As discussed elsewhere in this proposed rule, we are proposing a number of improvements to the calculation and establishment of the work, PE, and malpractice RVUs that would result in overall payment increases to primary care specialties of between 6 percent and 8 percent in CY 2010. These changes include a 6 percent increase in the work RVUs for office visits as a result of our proposal regarding consultation services; our proposed use of more accurate specialty-specific survey data on physician practice costs; our proposal to revise the utilization rate assumption for certain equipment; and our proposed use of updated and expanded malpractice premium data in the calculation of the malpractice RVUs.

MedPAC has in the past also recommended the establishment of a group panel of experts separate from the AMA RUC to review RVUs. This original March 2006 recommendation was summarized in its March 2008 Report to Congress:

"We also recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the AMA RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers."

The idea of a group of experts separate from the AMA RUC, to help the agency improve the review of relative values raises a number of issues. We seek broad public input on the following questions and other aspects of such an approach:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts (for example,

¹ All CPT codes copyright 2008 American Medical Association.

identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, etc.)?

- What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?
- How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

Also of interest are comments on the resources required to establish and maintain such a group. As MedPAC noted in its March 2006 Report with respect to the group of experts "we recognize that these recommendations will increase demands on CMS and urge the Congress to provide the agency with the financial resources and administrative flexibility needed to undertake them."

We welcome comments on these topics, as well as others of interest to the stakeholder community. We will consider these comments as we consider the establishment of a group of experts to assist us in our ongoing reviews of the PFS RVUs.

G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). We are proposing to revise our policies and regulations as described below in order to conform them to the statutory amendments.

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Prior to the enactment of the MIPPA, section 1833(c) of the Act provided that for expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, only 62½ percent of such expenses are considered to be incurred under Medicare Part B when determining the amount of payment and application of the Part B deductible in any calendar year. This

provision is known as the outpatient mental health treatment limitation (the limitation), and has resulted in Medicare paying only 50 percent of the approved amount for outpatient mental health treatment, rather than the 80 percent that is paid for most other outpatient services.

Section 102 of the MIPPA amends the statute to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment, which will result in an increase in the Medicare Part B payment for outpatient mental health services to 80 percent by CY 2014. When this section is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services. For CY 2010, section 102 of the MIPPA provides that Medicare will recognize 683/4 percent of expenses incurred for outpatient mental health treatment, which translates to a payment of 55 percent of the Medicareapproved amount. Section 102 of the MIPPA specifies that the phase out of the limitation will be implemented as shown in Table 9 (provided that the patient has satisfied his or her deductible).

TABLE 9—IMPLEMENTATION OF SECTION 102 OF THE MIPPA

Calendar year	Recognized incurred expenses (in percent)	Patient pays (in percent)	Medicare pays (in percent)
CY 2009 and prior calendar years	62.50	50	50
CY 2010 and CY 2011	68.75	45	55
CY 2012	75.00	40	60
CY 2013	81.25	35	65
CY 2014	100.00	20	80

At present, § 410.155(c) of the regulations includes examples to illustrate application of the current limitation. We are proposing to remove these examples from our regulations and, instead, to provide examples in this proposed rule, in our manual, and under provider education materials as needed. The following examples illustrate the application of the

limitation in various circumstances as it is gradually reduced under section 102 of the MIPPA. We note that although we have used the CY 2009 Part B deductible of \$135 for purposes of the examples below, the actual deductible amount for CY 2010 and future years will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for \$200 for

outpatient treatment of a patient's mental disorder. The Medicare-approved amount is \$180. Since clinical psychologists must accept assignment, the patient is not liable for the \$20 in excess charges. The patient previously satisfied the \$135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as shown in Table 10.

TABLE 10—EXAMPLE #1—CY 2010

1. Actual charges	\$200.00
2. Medicare-approved amount	180.00
3. Medicare incurred expenses (0.6875 × line 2)*	123.75
4. Unmet deductible	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	123.75
6. Medicare payment (0.80 × line 5)	99.00
7. Patient liability (line 2 minus line 6)	81.00

^{*}The recognized incurred expenses for 2010 are 683/4 percent.

Example #2: In 2012, a clinical social worker submits a claim for \$135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is

\$120. Since clinical social workers must accept assignment, the patient is not liable for the \$15 in excess charges. The limitation reduces the amount of incurred expenses to

75 percent of the approved amount. The patient previously satisfied \$70 of the \$135 annual Part B deductible, leaving \$65 unmet (see Table 11).

TABLE 11—EXAMPLE #2—CY 2012

1 Actual charges	\$135.00
1. Actual charges	φ133.00
2. Medicare-approved amount	120.00
3. Medicare incurred expenses (0.75 × line 2)*	90.00
4. Unmet deductible	65.00
5. Remainder after subtracting deductible (line 3 minus line 4)	25.00
6. Medicare payment (0.80 × line 5)	20.00
7. Patient liability (line 2 minus line 6)	100.00

^{*}The recognized incurred expenses for CY 2012 are 75 percent.

Example #3: In CY 2013, a physician who does not accept assignment submits a claim for \$780 for services in connection with the treatment of a mental disorder that did not

require inpatient hospitalization. The Medicare-approved amount is \$750. Because the physician does not accept assignment, the patient is liable for the \$30 in excess charges. The patient has not satisfied any of the \$135 Part B annual deductible (*see* Table

TABLE 12—EXAMPLE #3—CY 2013

1. Actual charges	\$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (0.8125 × line 2)*	609.38
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	474.38
6. Medicare payment (0.80 × line 5)	379.50
7. Patient liability (line 1 minus line 6)	400.50

^{*}The recognized incurred expenses for CY 2013 are 811/4 percent.

Example #4: A patient's Part B expenses during CY 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the \$135

Part B deductible. The physician accepts assignment and submits a claim for \$780. The Medicare-approved amount is \$750. Since the limitation will be completely phased out as of January 1, 2014, the entire \$750 Medicare-approved amount is recognized as the total incurred expenses

because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient (*see* Table 13).

TABLE 13—EXAMPLE #4—CY 2014

	i
1. Actual charges	\$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (1.00 × line 2)*	750.00
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	615.00
6. Medicare payment (0.80 × line 5)	492.00
7. Beneficiary liability (line 2 minus line 6)	258.00

^{*}The recognized incurred expenses for CY 2014 are 100 percent.

Section 102 of the MIPPA did not make any other changes to the outpatient mental health treatment limitation. Therefore, other aspects of the limitation will remain unchanged during the transition period between CYs 2010 and 2014. The limitation will continue to be applied as it has been in accordance with our regulation at § 410.155(b) which specifies that the limitation applies to outpatient treatment of a mental, psychoneurotic, or personality disorder, identified under the International Classification of Diseases (ICD) diagnosis code range 290-319. We use the place of service

code, and the procedure code to identify services to which the limitation applies.

Additionally, we are proposing to make technical corrections to § 410.155(b)(2) in order to update and clarify the services to which the limitation does not apply. Our proposed technical changes are as follows:

• Under § 410.155(b)(2)(ii), revise the regulation to specify the HCPCS code, M0064 (or any successor code), that represents the statutory exception to the limitation for brief office visits for the sole purpose of monitoring or changing drug prescriptions used in mental health treatment.

- At § 410.155(b)(2)(iv), we are proposing to revise the regulation to add neuropsychological tests and diagnostic psychological tests to the examples of diagnostic services that are not subject to the limitation when performed to establish a diagnosis.
- Under § 410.155(b)(2)(v), we are proposing to revise the regulation to specify the CPT code 90862 (or any successor code) that represents pharmacologic management services to which the limitation does not apply when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder.

Finally, we are proposing to add a new paragraph (c) to § 410.155 that provides a basic formula for computing the limitation during the phase-out period from CY 2010 through CY 2013, as well as after the limitation is fully removed from CY 2014 onward.

2. Section 131: Physician Payment, Efficiency, and Quality Improvements— Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term "eligible professional" means any of the following: (1) A physician; (2) A practitioner described in section 1842(b)(18)(C); (3) A physical or occupational therapist or a qualified speech-language pathologist; (4) A qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub. L. 109-432) (MIEA-TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, and 2009 are discussed in detail in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), CY 2008 PFS final rule with comment period (72 FR 66336 through 66353), CY 2009 PFS proposed rule (73 FR 38558 through 38575), and CY 2009 PFS final rule with comment period (73 FR 69817 through 69847). In addition, detailed information about the PQRI is available on the CMS Web site at http://www.cms.hhs.gov/PQRI.

b. Incentive Payments for the 2010 PQRI

For 2010, section 1848(m)(1)(B) of the Act authorizes the Secretary to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the reporting period for 2010. Although PQRI incentive payments are only

authorized through 2010 under section 1848(m)(1)(A) of the Act, section 1848(k)(2)(C) of the Act provides for the use of consensus-based quality measures for the PQRI for 2010 and subsequent years.

The PQRI incentive payment amount is calculated using estimated allowed charges for all covered professional services furnished under the PFS, not just those charges associated with the reported quality measures. "Allowed charges" refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A)) of the Act, "covered professional services" are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare Part B PFS are not included in the calculation of the incentive payment amount.

Under section 1848(m)(6)(C) of the Act, the "reporting period" for the 2008 through 2011 PQRI is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such "revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.'

We are also required by section 1848(m)(5)(F) of the Act to establish alternative criteria for satisfactorily reporting and alternative reporting periods for registry-based reporting and for reporting measures groups. Therefore, eligible professionals who meet the proposed alternative criteria for satisfactorily reporting for registrybased reporting and for reporting measures groups for the proposed 2010 alternative reporting periods for registry-based reporting and for reporting measures groups would also be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the proposed alternative reporting periods for 2010 PQRI registry-based reporting or for reporting measures groups.

The proposed PQRI reporting options for an individual eligible professional seeking to qualify for a 2010 PQRI incentive payment (that is, the proposed PQRI reporting mechanisms, proposed reporting periods, and proposed criteria for satisfactory reporting, including the proposed alternative reporting periods and alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups) are addressed in sections II.G.2.c. through II.G.2.f. of this proposed rule. The proposed 2010 PQRI quality measures and proposed 2010 PQRI measures groups are discussed in section II.G.2.i. of this proposed rule.

Prior to 2010, the PQRI was an incentive program in which determination of whether an eligible professional satisfactorily reported quality data was made at the individual professional level, based on the National Provider Identifier (NPI). Although the incentive payments were made to the practice(s) represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services, there were no incentive payments made to the group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measures data. To the extent individuals (based on the individuals' NPIs) satisfactorily reported data on PQRI quality measures that were associated with more than one practice or TIN, the determination of whether an eligible professional satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN.

However, section 1848(m)(3)(C)(i) of the Act requires that by January 1, 2010, the Secretary establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures for the PQRI for covered professional services for a reporting period, if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. Therefore, beginning with the 2010 PQRI, group practices who satisfactorily submit data on quality measures also would be eligible to earn an incentive payment equal to 2.0 percent of the

estimated total allowed charges for all covered professional services furnished by the group practice during the applicable reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, payments to a group practice by reason of the process described above shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. Therefore, an individual eligible professional who is participating in the group practice reporting option as a member of a group practice would not be able to separately earn a PQRI incentive payment as an individual eligible professional.

The process proposed to be used to determine whether a group practice satisfactorily submits data on quality measures for the 2010 PQRI is described in section II.G.2.g. of this proposed rule. The proposed measures on which a group practice would need to report in order to be treated as satisfactorily submitting data on quality measures for the 2010 PQRI are discussed in section II.G.2.j. of this proposed rule.

c. Proposed 2010 Reporting Periods for Individual Eligible Professionals

As we indicated above, section 1848(m)(6)(C) of the Act defines "reporting period" for 2010 to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. To be consistent with section 1848(m)(6)(C) of the Act and with prior years, we propose the 2010 PQRI reporting period for the reporting of individual PQRI quality measures through claims or a qualified electronic health record (EHR) (see section II.G.2.d. of this proposed rule for discussion of proposed 2010 PQRI reporting mechanisms) will be the entire year (that is, January 1, 2010 through December 31, 2010).

We also considered exercising our authority to revise the reporting period for claims-based reporting of individual measures by proposing to add an alternative reporting period beginning July 1, 2010 for claims-based reporting of individual measures. Doing so would make the reporting periods for claims-based reporting of individual measures consistent with the alternative reporting periods for registry-based reporting that have been in place since the 2008 PQRI. This would allow an eligible

professional to earn a PORI incentive payment equal to 2.0 percent of his or her estimated allowed charges for covered professional services furnished for the last half of 2010 if he or she satisfactorily reports data on individual PQRI quality measures through claims during the last half of 2010. We received input from a few stakeholders in support of a partial year reporting period for claims-based reporting of individual measures to give more eligible professionals the opportunity to begin reporting later in the year. Other stakeholders recommended that we offer the same reporting periods for all reporting mechanisms. We agree that having the same reporting periods for all reporting mechanisms may be less complex. We also agree that the addition of a 6-month reporting period may facilitate participation in PORI for certain eligible professionals. However, we do not believe that making a 6month reporting period available would serve to enhance the validity of results on measures reported or to maximize scientific validity as required under section 1848(m)(6)(C)(ii) of the Act. In addition, given our desire to transition from the use of the claims-based reporting mechanism as the primary reporting mechanism for clinical quality measures for PQRI after 2010 to rely more heavily on registry-based reporting (see section II.G.2.d. of this proposed rule for further discussion), we do not believe it appropriate to add a new 6month reporting period for claims-based reporting of individual measures. Given the fact that we seek to lessen reliance on the claims-based reporting mechanism for the PQRI after 2010, we believe the cost of adding a 6-month reporting period for claims-based reporting of individual measures outweighs any added flexibility that eligible professionals may receive in the short-term.

Nevertheless, we invite comments on the decision to not propose a 6-month reporting period for claims-based reporting of individual PQRI quality measures.

In addition, section 1848(m)(5)(F) of the Act requires, for 2008 and subsequent years, the Secretary to establish alternative reporting periods for reporting groups of measures and for registry-based reporting. To satisfy the requirements of section 1848(m)(5)(F) of the Act and to maintain program stability, we propose to retain the 2 alternative reporting periods from the 2008 and 2009 PQRI for reporting measures groups and for registry-based reporting: (1) The entire year; and (2) a 6-month reporting period beginning July 1. Therefore, for 2010, the proposed

alternative reporting periods for reporting measures groups and for registry-based reporting are: (1) January 1, 2010 through December 31, 2010; and (2) July 1, 2010 through December 31, 2010. We note that the 6-month reporting period, beginning July 1, 2010, is proposed to be available for reporting on measures groups and for reporting using the registry-based reporting mechanism only. For an eligible professional who satisfactorily reports measures groups or through the registrybased reporting mechanism for the 6month reporting period, the eligible professional would qualify to earn a PQRI incentive payment equal to 2.0 percent of his or her total estimated allowed charges for covered professional services furnished between July 1, 2010 and December 31, 2010 only. The incentive payment would not be calculated based on the eligible professional's charges for covered professional services for the entire year.

d. Proposed 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, the only way that eligible professionals could submit data on PQRI quality measures was by reporting the appropriate quality data codes on their Medicare Part B claims (claimsbased reporting). For the 2008 PQRI, we added a second reporting mechanism as required by section 1848(k)(4) of the Act, so that eligible professionals could submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups on their behalf (registry-based reporting). For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures

To promote the adoption of EHRs, we also conducted limited testing of a third reporting mechanism for the 2008 PQRI, which was the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those eligible professionals who participated in testing the EHR-based reporting mechanism. In the CY 2009 PFS proposed rule (73 FR 38564 through 38565), we described our plans to test the submission of clinical quality

data extracted from qualified EHR products for five 2008 PORI measures and proposed to accept PQRI data from EHRs and to pay PQRI incentive payments based on that submission for a limited subset of the proposed 2009 PQRI quality measures. However, as described in the CY 2009 PFS final rule with comment period (73 FR 69830), we did not finalize our proposal to allow eligible professionals to submit clinical quality data extracted from EHRs for purposes of receiving a PQRI incentive payment for 2009. Since the 2008 EHR testing process was not complete at the time of publication of the CY 2009 PFS final rule, we instead opted to continue to test the submission of clinical quality data extracted from EHRs in 2009 and provide no incentive payment to those eligible professionals participating in testing the EHR-based reporting mechanism in 2009.

For the 2010 PQRI, we are proposing to retain the claims-based reporting mechanism and the registry-based reporting mechanism. In addition, we are again proposing for the 2010 PQRI to accept PQRI quality measures data extracted from a qualified EHR product for a limited subset of the proposed 2010 PQRI quality measures, as identified in Table 20, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. We will make the determination as to whether accepting data from EHRs on quality measures is practical and feasible for the 2010 PQRI prior to publication of the CY 2010 PFS final rule with comment period. We will indicate in the CY 2010 PFS final rule with comment period whether we intend to finalize this proposal. If we finalize this proposal, then, unlike in prior years, an eligible professional would be able to earn a PQRI incentive payment through the EHR-based reporting mechanism in 2010.

We seek to offer more reporting mechanisms because we recognize that 1 mode of quality reporting does not suit all practices and our experience with the registry-based reporting mechanism thus far has been favorable. While the availability of multiple reporting mechanisms should increase opportunities for eligible professionals to satisfactorily report quality data for the PQRI, we also recognize that there are a number of limitations associated with claims-based reporting. On one hand, claims submission is available to nearly all eligible professionals. On the other hand, submission of quality data

on claims has certain drawbacks since the claims processing system was developed for billing purposes and not for the submission of quality data. As we noted in the CY 2009 PFS final rule with comment period (73 FR 69833), for example, measures with complex specifications, such as those that require multiple diagnosis codes are not as conducive to claims-based reporting and may be associated with a greater number of invalidly reported quality data codes. Similarly, when multiple measures share the same codes it may be difficult to determine which measure(s) the eligible professional intended to report through claims.

We believe that EHR-based reporting is a viable option for overcoming the limitations associated with claims-based reporting of quality measures. Therefore, we propose to add an EHR-based reporting mechanism for the 2010 PQRI in order to promote the adoption and use of EHRs and to provide both eligible professionals and CMS experience on EHR-based quality reporting.

Furthermore, on February 17, 2009, the President signed into law the American Recovery and Reinvestment Act (the Recovery Act) (Pub. L. 111-5). Section 4101(a) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act), which amends section 1848 of the Act to add new subsection (o), authorizes incentive payments under Medicare for certain eligible professionals who are "meaningful EHR users" beginning in 2011. However, the provisions in this proposed rule do not implement any HITECH Act statutory provisions. While our efforts to encourage the adoption and use of EHRs through testing EHRbased data submission in the 2008 and 2009 PQRI and our proposal to add an EHR-based reporting mechanism for the purpose of receiving a PQRI incentive payment for the 2010 PQRI could potentially provide invaluable experience and serve as a foundation for establishing the capacity for eligible professionals to send, and for CMS to receive, data on quality measures via EHRs, the provisions of the HITECH Act will be implemented in future notice and comment rulemaking.

In summary, we propose that for 2010, an eligible professional may choose to report data on PQRI quality measures through claims, to a qualified registry (for the qualification requirements for registries, see section II.G.2.i.(4) of this proposed rule), or through a qualified EHR product (for the

qualification requirements for EHR vendors and their products, see section II.G.2.i.(5) of this proposed rule). Depending on which PQRI individual quality measures or measures groups an eligible professional selects, however, one or more of the proposed reporting mechanisms may not be available for reporting a particular 2010 PQRI individual quality measure or measures group. The proposed 2010 reporting mechanisms through which each proposed 2010 PQRI individual quality measure and measures group could be reported is identified in Tables 14 through 15. We invite comments on the proposed reporting mechanisms for the 2010 PQRI, including our proposal to add an EHR-based reporting mechanism to the 2010 PQRI, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible.

While we propose to retain the claims-based reporting mechanism for 2010, we note that we are considering significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. This would be contingent upon there being an adequate number and variety of registries available and/or EHR reporting options. Potentially, we would retain claims-based reporting in years after 2010 principally for the reporting of structural measures, such as Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR), and circumstances where claims-based reporting is the only available mechanism for certain categories of eligible professionals to report on PQRI quality measures.

Reducing our reliance on the claimsbased reporting mechanism after 2010 will allow us and eligible professionals to devote available resources to maximizing the potential of registries and EHRs for quality measurement reporting. Both mechanisms hold the promise of more sophisticated and timely reporting on clinical quality measures. Clinical data registries allow the collection of more detailed data, including outcomes, without the necessity of a single submission contemporaneously with claims billing, which overcomes some of the limitations of the claims-based reporting mechanism. Registries can also provide feedback and quality improvement information based on reported data. Finally, clinical data registries can also receive data from EHRs, and therefore, serve as an alternative means to reporting clinical quality data extracted

from an EHR. As we continue to qualify additional registries, we believe that there will be a sufficient number of qualified PQRI registries by 2011 to make it possible to reduce or even discontinue the claims-based reporting mechanism for most measures after 2010. We invite comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

Řegardless of the reporting mechanism chosen by an eligible professional, there is no requirement for the eligible professional to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the criteria for satisfactory reporting of individual measures and measures groups described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, eligible professionals must ensure that they meet all requirements for their chosen reporting mechanism.

(1) Requirements for Individual Eligible Professionals Who Choose the Claims-Based Reporting Mechanism

For eligible professionals who choose to participate in the PORI by submitting data on individual quality measures or measures groups through the claimsbased reporting mechanism, the only requirement associated with claimsbased reporting that we are proposing apart from the proposed criteria for satisfactory reporting of individual measures and measures described below in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, is the submission of the appropriate PQRI quality data codes on the professionals' Medicare Part B claims. An eligible professional would be permitted to submit the quality data codes for the eligible professional's selected individual PQRI quality measures or measures group at any time during the 2010 reporting period. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2010 and December 31, 2010 must be processed by no later than February 28, 2011 to be included in the 2010 PQRI analysis.

(2) Requirements for Individual Eligible Professionals Who Choose the Registry-Based Reporting Mechanism

In order to report quality measures results and numerator and denominator data on the 2010 PQRI individual quality measures or measures group through a qualified clinical registry, we

propose that eligible professionals would need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQRI. The registry, acting as a data submission vendor, would submit registry-derived measures information to the CMS designated database for the PQRI, using a CMS-specified record layout. The record layout will be provided to the registry by CMS.

To maintain compliance with applicable statutes and regulations, our program and its data system must maintain compliance with the HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also must maintain compliance with the HIPAA requirements.

Éligible professionals choosing to participate in PQRI by submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures groups through the registry-based reporting mechanism for 2010 would need to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry.

The process and requirements that we propose to use to determine whether a registry is qualified to submit quality measures results and numerator and denominator data on PQRI quality measures or measures groups on an eligible professional's behalf in 2010 are described in section II.G.2.d. of this proposed rule. We will post on the PQRI section of the CMS Web site at http://www.cms.hhs.gov a list of qualified registries for the 2010 PQRI, including the registry name, contact information, and the 2010 measure(s) and/or

measures group(s) for which the registry is qualified and intends to report. We propose to post the names of 2010 PQRI qualified registries in 2 phases. In either event, even though a registry is listed as "qualified," we cannot guarantee or assume responsibility for the registry's successful submission of PQRI quality measures results and numerator and denominate data on PQRI quality measures or measures groups on behalf of eligible professionals.

In the first phase, we anticipate that by December 31, 2009, we will be able to, at minimum, post a list of those registries qualified for the 2010 PQRI based on: (1) Being a qualified registry for the 2008 and 2009 PQRI that successfully submitted 2008 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2010; and (3) the registry's compliance with the 2010 PQRI registry requirements. By posting this first list of qualified registries for the 2010 PQRI, we seek to make available the names of registries that can be qualified at the start of the 2010 reporting period. We do this to accommodate requests we have received from eligible professionals who wish to avoid claims-based reporting pending knowing whether a particular registry is qualified for the 2010 PORI.

In the second phase, we anticipate to complete posting of the list of qualified 2010 registries as soon as we have completed vetting the registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI, which we anticipate will be completed by no later than Summer 2010. An eligible professional's ability to report PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2010 PQRI being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2011. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible

professional from attempting to meet the criteria for satisfactory reporting through another 2010 PQRI reporting mechanism.

In addition to meeting the above proposed requirements specific to registry-based reporting, eligible professionals who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to qualify to earn a 2010 PQRI incentive payment. The criteria for satisfactory reporting of individual measures and measures groups are described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed

(3) Requirements for Individual Eligible Professionals Who Choose the EHR-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures through the EHR-based reporting mechanism, the only proposed requirements associated with EHRbased reporting other than meeting the criteria for satisfactory reporting of individual measures described in section II.G.2.e. of this proposed rule are to: (1) Select a qualified EHR product and (2) submit clinical quality data extracted from the EHR to a CMS clinical data warehouse. Provided that our 2009 EHR data submission testing process is successful, we propose to begin accepting submission of clinical quality data extracted from "qualified" EHRs on January 1, 2010, or as soon thereafter as is technically feasible. We propose that eligible professionals will have until March 31, 2011 to complete data submission through qualified EHRs for services furnished during the 2010 PQRI reporting period. The process that was used to determine whether an EHR vendor and its EHR product(s) are qualified to submit clinical quality data extracted from EHRs for the 2010 PQRI is described in section II.G.2.d.5. of this

The specifications for the electronic transmission of the proposed 2010 PQRI measures identified in Table 20 (section II.G.2.i.(4) of this proposed rule) as being under consideration for EHR-based reporting in 2010 will be posted on a public Web site when available. We will announce the availability and exact location of these specifications through familiar CMS communications channels, including the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI. The posting of

specifications for the electronic transmission of any particular measure prior to publication of the final rule does not signify that the measure will necessarily be selected for the 2010 PORI measure set, nor that EHR-based reporting will be accepted for that measure even if it may otherwise be included in the 2010 PQRI. However, by posting the specifications for electronic transmission of these measures, we seek to allow sufficient time for EHR vendors to adapt their products to support EHRbased capture and submission of data for these measures prior to the start of any 2010 PQRI reporting periods.

We do not propose any option to report measures groups through EHR-based reporting on services furnished during 2010. Because EHR-based reporting to CMS of data on quality measures would be new to PQRI for 2010, we propose to make available only the criteria applicable to reporting of individual PQRI measures.

We cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission promptly after we announce that the clinical data warehouse is ready to accept 2010 PQRI quality measures data through the EHR mechanism in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR. As we indicated above, data submission for the 2010 PQRI would need to be completed by March 31, 2011.

(4) Qualification Requirements for Registries

In order to be "qualified" to submit quality measures results and numerator and denominator data on PQRI quality measures and measures groups on behalf of eligible professionals pursuing incentive payment for the 2008 and 2009 PQRI, we required registries to complete a self-nomination process and to meet certain technical and other requirements. For the 2009 PQRI, registries that were "qualified" for 2008 did not need to be "re-qualified" for 2009 unless they were unsuccessful at submitting 2008 PQRI data (that is, failed to submit 2008 PQRI data per the 2008 PQRI registry requirements). Registries that were "qualified" for 2008 and wished to continue to participate in 2009 were only required to communicate their desire to continue participation for 2009 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2009 and their compliance with the 2009 PQRI registry requirements by March 31, 2009.

For the 2010 PQRI, we are again proposing to require a self-nomination process for registries wishing to submit 2010 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010. Similar to the 2008 and 2009 PQRI registry self-nomination process, the proposed registry self-nomination process for the 2010 PQRI would be based on a registry meeting specific technical and other requirements.

In order to be consistent with the registry requirements from prior program years, we propose that the 2010 registry requirements be substantially the same as for 2008 and 2009. Specifically, to be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose to report using this reporting mechanism under the 2010 PQRI, we propose that a registry would need to:

- Be in existence as of January 1, 2009.
- Be able to collect all needed data elements and calculate results for at least 3 measures in the 2010 PQRI program (according to the posted 2010 PQRI Measure Specifications).
- Be able to calculate and submit measure-level reporting rates by TIN/ NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports;
- Be able to separate out and report on Medicare Part B FFS patients;
 - Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);

- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);

• Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008 and 2009 PQRI. This layout will be provided to registries in 2010;

• Comply with a CMS-specified secure method for data submission, such as submitting its data in an XML file through an Individuals Access to CMS Systems (IACS) user account;

 Submit an acceptable "validation strategy" to CMS by March 31, 2010. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;

• Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in

the PQRI program; Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;

• Provide CMS access (if requested) to review the Medicare beneficiary data on which 2010 PQRI registry-based submissions are founded;

• Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and

• Provide CMS a signed, written attestation statement via mail or e-mail

which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete.

With respect to the submission of 2010 measure results and numerator and denominator data on measures groups, we propose to retain the following registry requirements from the 2009 PORI:

• Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;

• Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2010 or the 6-month reporting period of July 2010 through December 2010:

• Agree that the registry's data may be inspected by CMS under our oversight authority if non-Medicare patients are included in the patient sample;

• Be able to report data on all of the measures in a given measures group and on either 30 patients from January 1 through December 31, 2010 (note this patient sample must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2010 through December 31, 2010 reporting period or a minimum of 8 patients during the July 1, 2010 through December 31, 2010 reporting period) (see criteria for satisfactory reporting of measures groups described in section II.G.2.f. of this proposed rule for further information); and

• Be able to report the number of Medicare FFS patients and the number of Medicare Advantage patients that are included in the patient sample for a given measures group.

In addition to the above requirements, we propose the following new requirements for registries for the 2010 PQRI:

• Registries must have at least 25 participants;

 Registries must provide at least 1 feedback report per year to participating eligible professionals;

• Registries must not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);

 Registries must participate in ongoing 2010 PQRI mandatory support conference calls hosted by CMS (approximately 1 call per month); • Registries must provide a flow and XML of a measure's calculation process for each measure type that the registry intends to calculate; and

 Registries must use PQRI measure specifications to calculate reporting or performance unless otherwise stated.

These proposed new requirements are intended to improve the registry-based reporting mechanism by taking advantage of some of the registries' existing quality improvement functions, maximizing the registry's ability to successfully submit eligible professionals' quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups to CMS, and discouraging small physician offices or an individual eligible professional from self-nominating to become a qualified registry. We are concerned that an individual eligible professional or a small practice does not have the resources or capabilities to successfully submit quality measures results and numerator and denominator data on PQRI individual measures or measures groups through the registry data submission process.

We propose to post the final 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI by November 15, 2009. We anticipate that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010.

Similar to the 2009 PQRI, we propose that registries that were "qualified" for 2009 and wish to continue to participate in 2010 would not need to be "requalified" for 2010 unless they are unsuccessful at submitting 2009 PQRI data (that is, fail to submit 2009 PORI data per the 2009 PQRI registry requirements). We further propose that registries that were "qualified" for 2009, were successful in submitting 2009 PQRI data, and wish to continue to participate in 2010 would need to indicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by no later than October 31, 2009. Instructions regarding the procedures for submitting this letter will be provided to qualified 2009 PQRI registries on the 2009 PQRI registry support conference calls.

If a qualified 2009 PQRI registry fails to submit 2009 PQRI data per the 2009 PQRI registry requirements, we propose the registry would be considered unsuccessful at submitting 2009 PQRI data and would need to go through the full self-nomination process again to participate in the 2010 PQRI. By March 31, 2010, registries that are unsuccessful submitting quality measures results and numerator and denominator data for 2009 would need to be able to meet the 2010 PQRI registry requirements and go through the full vetting process again. Finally, as discussed further under

Finally, as discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above registry requirements would apply not only for the purpose of a registry qualifying to report 2010 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

(5) Qualification Requirements for EHR Vendors and Their Products

In the CY 2009 PFS final rule with comment period (73 FR 69830), we announced our intent to qualify EHR vendors and their specific products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse so that we may potentially begin to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in future PQRI reporting. We stated that we anticipate posting on the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI, by December 31, 2008, a list of requirements that EHR vendors must be able to meet in order to self-nominate to have their product "qualified" to potentially be able to submit quality measures data for the 2010 PQRI to CMS. We also stated that qualifying EHR vendors ahead of actual data submission will facilitate the live data submission process.

On December 31, 2008, the "Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program," was posted on the Reporting page of the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage, which described the EHR vendor requirements and the EHR vendor self-nomination process.

The vendor's EHR system must be updated according to the Draft 2009 EHR specifications posted on the QualityNet Web site at http://www.qualitynet.org in order for an EHR vendor and its product to qualify to submit test information on 2009 PQRI measures, and for possible EHR data

submission for future PQRI reporting years. In addition, the 2009 PQRI EHR test-vendors must meet the following requirements:

 Be able to collect and transmit all required data elements according to the 2009 EHR Specifications.

 Be able to separate out and report on Medicare Part B FFS patients only.

• Be able to include TIN/NPI information submitted with an eligible professional's quality data.

• Be able to transmit this data in the CMS-approved format.

• Comply with a secure method for data submission.

• Enter into and maintain with its participating professionals an appropriate legal arrangement that provides for the EHR vendor to receive patient-specific data from the eligible professional, as well as the EHR vendor's disclosure of protected health information on behalf of eligible professionals who wish to participate in the 2009 PQRI EHR test program.

 Obtain and keep on file signed documentation that each NPI whose data is submitted to the EHR vendor has authorized the EHR vendor to submit patient data to CMS for the purpose of PQRI testing. This documentation must meet the standards of applicable law, regulations, and contractual or business

associate agreements.

As described in the "Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program," which is posted on the Reporting page of the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI/ $20_Reporting.\bar{a}sp\#TopOfPage$, EHR vendors who wish to qualify to participate in the 2009 PORI EHR test program were required to submit a selfnomination letter requesting inclusion in the 2009 EHR testing process by February 13, 2009. All nominees would then go through a vetting process. Those nominees passing this vetting process would be asked to submit test data (that is, mock-up data) or to submit live test data from some of their clients (users) with their permission. Vendors who successfully submit their test data would also need to be able to adapt their system to any changes in the measure specifications that may arise due to Healthcare Information Technology Standards Panel (HITSP) or Certification Commission for Healthcare Information Technology (CCHIT) adoption of quality measure data reporting criteria.

It is expected that the process for qualifying self-nominated EHR vendors may conclude in 2009. At the conclusion of this process, we propose that those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI as a "qualified" EHR product (that is, the name of the vendor software product and the version that is qualified), which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2010 PQRI, if and when, EHR submission is included in the 2010 PQRI as a PQRI reporting mechanism.

As discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above EHR vendor requirements would apply not only for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to submit data extracted from the EHR for the 2010 PQRI, but also for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to electronically submit data extracted from the EHR for the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

During 2010, we expect to use the self-nomination process described in the "Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program" posted on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/ *PQRI/20 Reporting.asp#TopOfPage*, to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for program years after 2010. We anticipate that the requirements will be similar to those used to qualify EHR products for the 2009 PQRI EHR testing, but they may be modified based on the results of our 2009 EHR testing. At the conclusion of this process, sometime in late 2010, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/ PQRI as a "qualified" EHR product, which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2011 PQRI or subsequent years, if and when, EHR submission is included as a PQRI reporting mechanism for years after 2010.

e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

Under section 1848(m)(3)(A) of the Act, the criteria for satisfactorily

submitting data on individual quality measures through claims-based reporting require the reporting of at least 3 applicable measures in at least 80 percent of the cases in which the measure is reportable. If fewer than 3 measures are applicable to the services of the professional, the professional may meet the criteria by reporting on all applicable measures (that is, 1 to 2 measures) for at least 80 percent of the cases where the measures are reportable. It is assumed that if an eligible professional submits quality data codes for a particular measure, the measure applies to the eligible professional.

İn prior program years, when we were required, under section 1848(m)(5)(F) of the Act, to establish alternative criteria for satisfactorily reporting using the registry-based reporting mechanism, we decided that the criteria for registrybased reporting of individual measures should be consistent with the criteria for claims-based reporting of individual measures. Thus, we adopted the same criteria for satisfactory reporting of individual measures through registrybased reporting as the criteria for satisfactory reporting of individual measures through claims-based reporting except that an eligible professional could choose to report through the registry-based reporting mechanism only if there are at least 3 PQRI quality measures applicable to the services of the professional. For the 2008 or 2009 PQRI, eligible professionals could not satisfactorily report PQRI measures through the registry-based reporting mechanism by reporting on fewer than 3 measures.

For years after 2009, section 1848(m)(3)(D) of the Act authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have received from stakeholders via the invitation to submit suggestions for the 2010 PQRI reporting options posted on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI in April 2009, we propose 3 criteria for satisfactory reporting of individual PORI quality measures for 2010. In an effort to continue to be consistent with the criteria of satisfactory reporting used in prior PQRI program years, we propose to retain the following 2 criteria with respect to satisfactorily reporting data on individual quality measures in circumstances where 3 or more individual quality measures apply to the services furnished by an eligible professional:

• Report on at least 3 2010 PQRI measures (unless fewer than 3 2010

PQRI measures apply to the services furnished by the eligible professional); and

• Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

These criteria would apply to all proposed 2010 PQRI reporting mechanisms available for reporting individual PQRI quality measures (that is, claims-based reporting, registry-based reporting, and EHR-based

reporting).

If an eligible professional has fewer than 3 PQRI measures that apply to the professional's services, then the professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 proposed criteria:

- Reporting on all measures that apply to the services furnished by the professional (that is 1 to 2 measures);
- Reporting each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We propose that, as in previous years, these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would be available for the claims-based reporting mechanism only. An eligible professional who has fewer than 3 PQRI measures that apply to the professional's services would not be able to meet the criteria for satisfactory reporting by reporting on all applicable measures (that is, 1 or 2 measures) through the registry-based reporting mechanism.

While we have received input from several stakeholders requesting that we permit an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism if fewer than 3 measures apply to him or her, doing so would be inefficient. First, in addition to needing to analyze the data submitted to us by the registry, we would have to analyze the claims data to ensure that no additional measures are applicable to the eligible professional, much like what we do under the Measure Applicability Validation process for claims-based reporting. Second, we would also have to analyze the claims data to ensure that the eligible professional had not attempted to report additional measures through claims. For these reasons, we are not proposing to permit eligible professionals who choose the registrybased or EHR-based reporting mechanism to report on individual quality measures to report on fewer than 3 measures if only 1 or 2 measures apply to the services they furnish.

Based on the previously stated assumption that a measure applies to the eligible professional if an eligible professional submits quality data codes for a particular measure, we propose that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism in 2010 may be subject to the Measure Applicability Validation process, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures. This process was applied in the 2007 and 2008 PQRI. When an eligible professional reports on fewer than 3 measures, we propose to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of professional). If an eligible professional who reports on fewer than 3 measures in 2010 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the professional would not qualify to receive a 2010 PORI incentive payment. Additional information on the Measure Applicability Validation process can be found on the Analysis and Payment page of the PORI section of the CMS Web site at http://www.cms.hhs.gov/ PQRI.

In addition to the above criteria related to the number of measures on which an eligible professional would be required to report and the frequency of reporting, we propose a third criterion for satisfactory reporting of individual measures. Based on our authority to revise the criteria for satisfactory reporting under section 1848(m)(3)(D) of the Act, we propose that an eligible professional also be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period, as detailed below. Establishing a minimum patient sample size requirement would enhance the scientific validity of eligible professionals' performance results and encourage eligible professionals to select to report only measures that are representative of the types of services they typically provide in their practice. If, for example, an eligible professional selects 3 patient-level measures (that is, measures in which the required

reporting frequency is a minimum of once per reporting period per individual eligible professional) where only one of his or her Medicare Part B FFS patients are eligible for the measures and there is no minimum patient sample size requirement, then the eligible professional currently could qualify to earn a PQRI incentive payment by reporting PQRI quality measures data only 3 times during the entire reporting period. We believe that information on such a small sample of cases would be insufficient to do any meaningful analysis of the eligible professional's performance on the reported measure. We also believe that a minimum patient sample size requirement would prevent an eligible professional from purposely selecting measures that apply to only a few of their patients.

Regardless of the reporting mechanism chosen by the eligible professional, we propose that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B FFS patients for the 12-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. This proposed number is

based on our experience with the 2007 PQRI and the limited information we have available regarding the 2008 PORI reporting experience. For the 2007 PQRI measures, where the only reporting period was a 6-month reporting period beginning July 1, 2007, the median number of instances in which an eligible professional could have reported a 2007 PQRI measure was, on average, 9 eligible instances per measure. If we assume that the number of eligible instances for the first half of 2007 were similar to the number of eligible instances in the second half of 2007, then we can assume that the median number of eligible instances was an average of 18 instances per measure for the entire year. Preliminary information from the 2008 PQRI, based on data through September 2008, indicate that the median number of instances in which an eligible professional could have reported a 2008 PQRI measure was, on average, 18 eligible instances per measure. Since eligible professionals are not required to report a measure for all eligible cases, we based the proposed minimum patient sample size threshold on 80 percent of 18 eligible instances, which is 14.4.

Similarly, for the 6-month reporting period (available for registry-based reporting only), we propose that the minimum patient sample size for reporting on individual quality measures be 8 Medicare Part B FFS patients seen during the 6-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. We welcome comments on the proposal to add a minimum patient sample size criterion to the criteria for satisfactory reporting of data on individual quality measures. In addition, we invite comments on the specific thresholds proposed for the 12month reporting period (available for claims-based, registry-based, and EHRbased reporting) and for the 6-month reporting period (available for registrybased reporting only) for reporting individual quality measures.

The proposed 2010 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 14 and are arranged by reporting mechanism and reporting period.

Table 14—Proposed 2010 Criteria for Satisfactory Reporting of Data on Individual PQRI Quality Measures, by Reporting Mechanism and Reporting Period

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	 Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies. 	January 1, 2010-December 31, 2010.
Registry-based reporting	 Report at least 3 PQRI measures; Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies. 	January 1, 2010-December 31, 2010.
Registry-based reporting	 Report at least 3 PQRI measures; Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and Report at least 1 PQRI measure on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measure applies. 	July 1, 2010-December 31, 2010.
EHR-based reporting	 Report at least 3 PQRI measures; Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies. 	January 1, 2010-December 31, 2010.

As illustrated in Table 14, there are a total of 4 proposed reporting options, or ways in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures for the 2010 PQRI. Each reporting option consists of the criteria for satisfactorily reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. While eligible professionals may potentially qualify as satisfactorily reporting individual quality measures under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

As described above, section 1848(m)(5)(F) of the Act requires that, for 2008 and subsequent years, the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. In establishing these alternatives in prior years, we have labeled these groups of measures "measures groups." We have previously defined "measures groups" as a subset of four or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

In the 2008 and 2009 PQRI, measures groups were reportable through claimsbased or registry-based reporting. For the 2008 and 2009 PQRI, there were 2 basic sets of criteria for satisfactory reporting measures groups through claims-based or registry-based reporting: (1) The reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the reporting period; or (2) the reporting of at least 1 measures group for a specified number of consecutive patients to whom the measures group applies during the reporting period. For registry-based reporting in the 2008 and 2009 PQRI, we allowed eligible professionals to include some non-Medicare Part B FFS patients in the consecutive patient sample under the second set of criteria. For registry-based reporting quality measures results and numerator and denominator data on measures groups in 2009, we also added to the first set of criteria a requirement

to report the measures group on a minimum number of patients commensurate with the reporting period duration.

For the 2010 PQRI, we again propose 2 basic sets of criteria for satisfactory reporting on measures group. Both sets of criteria would apply to the claims-based and registry-based reporting mechanism. As discussed in section II.G.2.d.(3) of this proposed rule, we are not proposing to make the EHR-based reporting mechanism available for reporting on measures groups in 2010.

The first set of proposed criteria, which we propose to make available for either the 12-month or 6-month reporting period in 2010, would be consistent with the 2009 criteria for satisfactory reporting of measures groups through registry-based reporting, which require the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the applicable reporting period (with reporting required on a minimum number of Medicare Part B FFS patients commensurate with the reporting period duration). In the 2009 PQRI, there was a requirement under these criteria to report each measures group on at least 30 Medicare Part B FFS patients for the 12-month reporting period and at least 15 Medicare Part B FFS patients for the 6-month reporting period for registry-based reporting of measures groups. For the 2010 PQRI, we propose to revise the requirement by making these criteria applicable to both registry-based and claims-based reporting and to change the number of Medicare Part B FFS patients on which an eligible professional would be required to report a measures group. We propose to require an eligible professional who chooses to report on measures groups based on reporting on 80 percent of applicable patients to report on a minimum of 15 Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6month reporting period, regardless of whether the eligible professional chooses to report the measures group through claims-based reporting or registry-based reporting. We propose to revise the required minimum sample size to make the proposed 2010 criteria for satisfactory reporting of measures groups consistent with the proposed 2010 criteria for satisfactory reporting of individual measures. We invite comments on our proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures. We especially would be interested in comments with respect to

our proposal to revise the minimum sample size requirement related to satisfactory reporting on measures group through the registry-based reporting mechanism so that the criteria for satisfactory reporting of measures groups, regardless of reporting mechanism, would be identical to those proposed for reporting individual measures.

The second set of proposed criteria, which we propose to make available for the 12-month reporting period only, would be based on reporting on a measures group on a specified minimum number of patients. The second set of criteria would require reporting on at least 1 measures group for at least 30 patients seen between January 1, 2010 and December 31, 2010 to whom the measures group applies. Unlike the 2009 PQRI, which required that eligible professionals report on consecutive patients (that is, patients seen in order, by date of service), the 30 patients on which an eligible professional would need to report a measures group for 2010 would not need to be consecutive patients. The eligible professional would be able to report on any 30 patients seen during the reporting period to which the measures group applies. We propose to remove the requirement to report on patients seen consecutively by date of service because our preliminary analysis of the 2008 PORI claims-based reporting experience through September 2008 suggests that this requirement is difficult for professionals to apply accurately to meet the criteria for satisfactory reporting of measures groups. In addition, the questions we receive from eligible professionals indicate that many eligible professionals are not clear on how to determine which patients are "consecutive" and should be included in the patient sample. We believe that any adverse effect on the reliability or validity of the quality information received as a result of the removal of the requirement to report on patients seen consecutively and allowing eligible professionals to report on any 30 patients would be minimal. When eligible professionals report measures groups, they are required to report on multiple measures for a given clinical condition or focus, which makes it harder for them to selectively choose patients in an attempt to improve their performance results. We invite comments on our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

As in previous years, we propose that for 2010, the patients, for claims-based

reporting, would be limited to Medicare Part B FFS patients. We receive claims on Medicare patients only. For registrybased reporting, however, we propose that the patients could include some,

but not be exclusively, non-Medicare Part B FFS patients.

The proposed 2010 criteria for satisfactory reporting on measures groups are summarized in Table 15,

which is arranged by reporting mechanism and reporting period.

TABLE 15—PROPOSED 2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	Report at least 1 PQRI measures group;	January 1, 2010–December 31, 2010.
Claims-based reporting	 Report each measures group for at least 30 Medicare Part B FFS patients. Report at least 1 PQRI measures group; 	January 1, 2010–December 31, 2010.
	Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and	
	Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	heled 0040 December 04
Claims-based reporting	Report at least 1 PQRI measures group;	July 1, 2010–December 31, 2010.
	Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and	January 1, 2010-December 31, 2010.
	Report each measures group on at least 8 Medicare Part B FFS patients seen	
Registry-based reporting	during the reporting period to which the measures group applies. • Report at least 1 PQRI measures group;	January 1, 2010-December 31, 2010.
	Report each measures group for at least 30 patients. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	
Registry-based reporting	Report at least 1 PQRI measures group;	January 1, 2010–December 31, 2010.
	 Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and 	
Registry-based reporting	 Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. Report at least 1 PQRI measures group; 	July 1, 2010-December 31,
riegistry-based reporting	riepoit at least 11 Qtil measures group,	2010.
	 Report each measures group for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and 	
	 Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies. 	

As illustrated in Table 15, there are a total of 6 proposed reporting options, or ways in which an eligible professional may meet the proposed criteria for satisfactory reporting of measures groups for the 2010 PQRI. Each reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, while eligible professionals may potentially qualify as satisfactorily reporting on measures groups under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

As stated previously, section 1848(m)(3)(C)(i) of the Act requires the Secretary to establish and have in place a process by January 1, 2010 under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under PQRI if, in lieu of reporting measures under PQRI, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Section 1848(m)(3)(C)(ii) of the Act requires that this process provide for the use of a statistical sampling model to submit data on measures, such as the model

used under the Medicare Physician Group Practice (PGP) demonstration project under section 1866A of the Act.

In addition, payments to a group practice under section 1848(m) of the Act by reason of the process proposed herein shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures (that is, prohibits double payments). Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice (that is, for each TIN/NPI combination) satisfactorily reported on PQRI quality measures, we will begin making incentive payments to group practices based on the determination that the group practice, as a whole (that is, for the TIN), satisfactorily reports on

PQRI quality measures for 2010. In addition, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that satisfactorily reports under the proposed group practice reporting option would not be eligible to earn a separate PQRI incentive payment for 2010 on the basis of his or her satisfactorily reporting PQRI quality measures data at the individual level.

(1) Definition of "Group Practice"
As stated above, section
1848(m)(3)(C)(i) of the Act authorizes
the Secretary to define "group practice."
For purposes of determining whether a
group practice satisfactorily submits
PQRI quality measures data, we propose
that a "group practice" would consist of
a physician group practice, as defined
by a TIN, with at least 200 or more
individual eligible professionals (or, as
identified by NPIs) who have reassigned
their billing rights to the TIN.

Generally, our intent is to build on an existing quality reporting program that group practices may already be familiar with by modeling the PQRI group practice reporting option after the PGP demonstration. Since the PGP demonstration is a demonstration program for large group practices, one of the requirements for group practices participating in the PGP demonstration is for each practice to have 200 or more members. To be consistent with the PGP demonstration, we also propose to limit initial implementation of the PQRI group practice reporting option for 2010 to similar large group practices. As we gain more experience with the group practice reporting option, we may consider lowering the group size threshold in the future. We invite comments on the proposed definition of 'group practice' and our proposal to limit initial implementation of the PQRI group practice reporting option in 2010 to practices with 200 or more individual

In order to participate in the 2010 PQRI through the group practice reporting option, we propose to require group practices to complete a selfnomination process and to meet certain technical and other requirements. Group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. We propose that each group practice would be required to meet the following requirements:

eligible professionals.

 Have an active Individuals Access to CMS Systems (IACS) user account;

- Provide CMS or a CMS designee with the group practice's TIN and the NPI numbers and names of all eligible professionals who will be participating as part of the group practice (that is, all individual NPI numbers associated with the group practice's TIN). This information must be provided in an electronic format specified by CMS, such as in an Excel spreadsheet; and
- Agree to have the group practice's PQRI quality measurement performance rates for each measure publicly reported by posting of the results on a CMS Web site.

We propose to post the final participation requirements for group practices, including the exact date by which group practices that wish to participate in the 2010 PQRI through the group practice reporting option must submit a self-nomination letter and other instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI by November 15, 2009. We anticipate that group practices that wish to self-nominate for 2010 will be required to do so by the end of the first quarter of 2010, but not later than the end of the second quarter of 2010. Upon receipt of the selfnomination letters we will assess whether the participation requirements proposed above have been met by each self-nominated group practice.

(2) Process for Physician Group Practices To Participate as Group Practices and Criteria for Satisfactory Reporting Data on Quality Measures by Group Practices

For physician groups selected to participate in the PQRI group practice reporting option for 2010, we propose the reporting period would be the 12month reporting period beginning January 1, 2010. We propose that group practices would be required to submit information on these measures using a data collection tool based on the data collection tool used in CMS' Medicare Care Management Performance (MCMP) demonstration and the quality measurement and reporting methods used in CMS' PGP demonstration. We propose that physician groups selected to participate in the 2010 PQRI through the group practice reporting option would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration and that target high-cost chronic conditions and preventive care. These quality measures are identified in Table 34. Additional information on the MCMP and PGP demonstrations is posted on the Medicare Demonstrations

section of the CMS Web site at http://www.cms.hhs.gov/
DemoProjectsEvalRpts/MD/
list.asp#TopOfPage. Although our
proposed process for physician groups
to participate in PQRI as a group
practice incorporates some
characteristics and methods from the
PGP demonstration and the MCMP
demonstration, the PQRI group practice
reporting option will be a separate
program with its own specifications and
methodology from the PGP and MCMP
demonstration programs.

The proposed quality measures identified in Table 34 are based on a subset of the Doctor's Office Quality (DOQ) quality measures set developed and specified under the direction of CMS and which are used in the PGP and/or MCMP demonstration programs. Contributors to the development of the DOQ measure set included the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the American College of Cardiology (ACC), the American Heart Association (AHA), the National Diabetes Quality Improvement Alliance, the National Committee for Quality Assurance (NCQA), and the Veterans Health Administration (VA) and, in most instances, overlap with proposed 2010 PQRI measures. These quality measures are grouped into four disease modules: diabetes; heart failure; coronary artery disease; and preventive care services.

As part of the data submission process, we propose that, beginning in 2011, each group practice would be required to report quality measures with respect to services furnished during the 2010 reporting period (that is, January 1, 2010 through December 31, 2010) on an assigned sample of Medicare beneficiaries. We propose to analyze the January 1, 2010 through October 29, 2010 (that is, the last business day of October 2010) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration. Assigned beneficiaries are limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries do not include Medicare Advantage enrollees. Essentially, a beneficiary would be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient E/M allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2010 and October 29, 2010). Beneficiaries with

only 1 visit to the group practice between January 1, 2010 and October 29, 2010 would be eliminated from the group practice's assigned patient sample. Once the beneficiary assignment has been made for each physician group, each physician group would be required to report the quality measures on a random sample of the assigned beneficiaries per disease module or preventive care measure. For each disease module or preventive care measure, the physician group would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). In the fourth quarter of 2010, we would pull a random sample of assigned beneficiaries for each disease module or preventive care measure and provide the sample to the physician group consistent with the methods used in the PGP demonstration. Identical to the sampling method used in the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent of the assigned beneficiaries to participate in the group practice reporting option.

We propose a unique reporting mechanism for the group practice reporting option that would not be available to individual eligible professionals participating in the 2010 PORI. We propose that each physician group selected to participate in the group practice reporting option would have access to a database (that is, a data collection tool) that would include the assigned beneficiary sample and the quality measures. This data collection tool was originally developed for use in the PGP demonstration, updated for use in the MCMP demonstration, and would be updated as needed for use in the PQRI. The assigned beneficiaries' demographic and utilization information would be prepopulated based on claims data. We anticipate being able to provide the selected physician groups with access to this prepopulated database by the fourth quarter of 2010. The physician group would be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures would include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure would include a sample of the assigned beneficiaries who meet the eligibility

criteria for that quality measure module or preventive care measure.

We invite comments on our proposal to adopt the PGP demonstration's quality measurement and reporting methods for the PQRI group practice reporting option. We specifically request comments on the proposed patient assignment methodology and our proposal to use a data collection tool based on the one used in the MCMP demonstration as the reporting mechanism for physician groups selected to participate in the PQRI group practice reporting option.

We propose 2 criteria for satisfactory reporting of quality measures by a physician group. First, the physician group would be required to report completely on all of the proposed modules and measures listed in Table 34. Second, the physician group would be required to report on the first 411 consecutively assigned Medicare beneficiaries per disease module or preventive care measure. This is identical to the reporting criteria used in the PGP demonstration. By building on an existing demonstration program that large group practices may already have experience with, we hope to minimize burden on both group practices and CMS. The sample that we pull for and provide to each physician group would include more than the 411 assigned beneficiaries (the sample would include an over sample of approximately 50 percent). More beneficiaries are provided in the sample than the group practice is required to report on in order to account for beneficiaries included in the sample who cannot be confirmed with the diagnosis for a particular disease module or whose medical information may not be able to be located within the physician group's systems.

h. Statutory Requirements and Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

(1) Statutory Requirements for Measures Proposed for Inclusion in the 2010 PQRI

As a result of section 131(b) of the MIPPA, the statutory requirements with respect to the use of quality measures for the 2010 PQRI are different from the statutory requirements for previous program years. For the 2007 PQRI, section 1848(k)(2)(A)(i) of the Act required the Secretary to generally select the quality measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program. For the 2008 and 2009 PQRI, section 1848(k)(2)(B) of the Act required that the quality measures be measures that have been adopted or endorsed by

a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. For purposes of reporting data on quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, subject to the exception noted below, section 1848(k)(2)(C)(i) of the Act, as added by MIPPA, requires that the quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act, as added by section 183 of the MIPPA. On January 14, 2009, the U.S. Department of Health and Human Services awarded the contract required under section 1890(a) of the Act to the National Quality Forum (NQF).

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, however, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in certain specified circumstances, each proposed 2010 PQRI quality measure would need to be endorsed by the NQF by July 1, 2009. In those circumstances in which a feasible and practical measure has not been endorsed by the NQF, we believe that all other proposed 2010 PQRI quality measures would need to have at least been adopted by the AQA or another organization with comparable consensus-organization characteristics. However, in January 2009, the AQA announced that it will no longer be adopting measures and we are not aware of any other organizations with consensus-organization characteristics (see 73 FR 38565 through 38566 for discussion of the considerations applied in determining whether an entity is a consensus organization). Therefore, our policy with respect to identifying exceptions under section 1848(k)(2)(C)(ii) of the Act would be to give due consideration to measures that have been endorsed by the NQF. As a result, in reviewing measures for possible inclusion in the 2010 PQRI quality measure set, we propose that any new quality measures proposed for the 2010 PQRI must be NQF-endorsed

by July 1, 2009, while any proposed 2010 PORI quality measures selected from the 2009 PQRI quality measure set would need to have been adopted by the AQA as of January 31, 2009, if the measure still is not endorsed by the

NQF by July 1, 2009.

In addition, section 1848(k)(2)(D) of the Act requires that for each 2010 PQRI quality measure, "the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish." Measure developers generally include a public comment phase in their measure development process. As part of the measure development process, measure developers typically solicit public comments on measures that they are testing in order to determine whether additional refinement of the measure(s) is needed prior to submission for consensus endorsement. For example, information on the measure development process employed by us when CMS or a CMS contractor is the measure developer is available in the "Measures Management System Blueprint" found on the CMS Web site at http://www.cms.hhs.gov/apps/QMIS/ mmsBlueprint.asp.

Eligible professionals also have the opportunity to provide input on a measure as the measure is being vetted through the NOF consensus endorsement process (and previously, the AQA consensus adoption process). In particular, the NQF employs a public comment period for measures vetted through its consensus endorsement process (and previously, for the AQA, its consensus adoption process).

Finally, eligible professionals have an opportunity to provide input on the measures proposed for inclusion in the 2010 PQRI through this proposed rule, which provides a 60-day comment period. Accordingly, with regard to the 2010 PQRI, we believe we have satisfied this requirement in multiple ways.

(2) Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

Consistent with the statutory requirements described in section II.G.2.h.(1) of this proposed rule, we propose to apply the following considerations with respect to the selection of 2009 PQRI quality measures proposed for inclusion in the 2010 PQRI quality measure set:

 Where some 2009 PQRI quality measures have been endorsed by the NQF and others have not, those 2009 PQRI quality measures that have been specifically considered by NQF for possible endorsement, but NQF has

declined to endorse it, are not proposed for inclusion in the 2010 PORI quality measure set (that is, we propose to retire

the measure for 2010).

· In circumstances where no NQFendorsed measure is available, we propose to exercise the exception under section 1848(k)(2)(C)(ii) of the Act. Under these circumstances, a 2009 PQRI quality measure that previously (that is, prior to January 31, 2009) has been adopted by the AQA would meet the requirements under the Act and we propose that it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.

• Although we do not propose to include any 2009 PQRI measures that have not been endorsed by the NQF or adopted by the AQA in the final 2010 PQRI quality measure set, we acknowledge that section 1848(k)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF) as long as an area or medical topic for which a feasible and practical NQFendorsed measure is not available has been identified and due consideration has been given to measures that have been endorsed by the NOF and/or, prior to January 31, 2009, adopted by the AQA.

- The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physiciancontrolled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.
- 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics

indicate a lack of significant reporting and usage were not considered for inclusion in the 2010 PQRI

In addition to reviewing the 2009 PQRI measures and previously retired measures, for purposes of developing the proposed 2010 PQRI measures, we have reviewed and considered measure suggestions including comments received in response to the CY 2009 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions posted on the PQRI section of the CMS Web site in February 2009 were also reviewed and considered for purposes of our development of the list of proposed 2010 PQRI quality measures.

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2009 or any prior year), we propose to apply the following considerations, which include many of the same considerations applied to the selection of 2009 PQRI quality measures for proposed inclusion in the 2010 PQRI quality measure set described above:

High Impact on Healthcare.

- Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.
- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.

NQF Endorsement.

- + Measures must be NQF-endorsed by July 1, 2009 in order to be considered for inclusion in the 2010 PQRI quality measure set.
- + Although we do not propose to include any new measures that are not endorsed by the NQF by July 1, 2009 in the final 2010 PQRI quality measure set, we acknowledge that section (k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As

long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by Secretary.

+ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physiciancontrolled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

Address Gaps in PQRI Measure Set.

+ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least 3 measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

 Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we propose to apply to the selection of measures for 2010, regardless of whether the measure is a 2009 PQRI measure or not, are:

 Measures that are functional, which is to say measures that can be

technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2009 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claimsbased, have not been included in the 2010 PQRI. For example, in some cases, we have proposed to replace existing 2009 PQRI measures with updated and improved measures that are less technically challenging to report.

 For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible. For example, we are proposing to limit reporting of some measures that previously were available for claimsbased reporting and registry-based reporting to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism. For further discussion of the proposed reporting mechanisms, see section II.G.2.d. of this proposed rule.

We also reviewed 33 measures that have been retired from the PQRI in previous years using the considerations for selecting proposed measures for the 2010 PQRI discussed above. None were found to be eligible for inclusion in the 2010 PQRI quality measure set because they did not meet the criteria described above.

We welcome comments on the implication of including or excluding any given measure or measures proposed herein in the final 2010 PQRI quality measure set and on our approach in selecting measures. We recognize that some commenters may also wish to recommend additional measures for inclusion in the 2010 PQRI measures that we have not herein proposed. While we welcome all constructive comments and suggestions, and may consider such recommended

measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2010 measure set.

As discussed above, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2010 PORI that are recommended to CMS via comments on this proposed rule have not been placed before the public with opportunity for the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as PQRI measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in PQRI. Thus, such additional measures recommended for selection for the 2010 PQRI via comments on this proposed rule cannot be included in the 2010 measure set. However, as discussed above, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2010 PQRI measures, for purposes of identifying measures for possible use in future years' PQRI or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the measure developer/ owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed PORI measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 16 through 34. Contact information for the 2009 PQRI measure developers is listed in the "2009 PQRI Quality Measures List," which is available on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI.

i. Proposed 2010 PQRI Quality Measures for Individual Eligible Professionals

As stated previously, individual eligible professionals have the choice of reporting PQRI quality measures data on either individual quality measures or on measures groups.

Consistent with the statutory requirements for measures included in the 2010 PORI and other considerations for identifying proposed 2010 quality measures discussed in section II.G.2.h.(1) and II.G.2.h.(2), respectively, of this proposed rule, the individual quality measures identified for use in the 2010 PQRI will be selected from those we propose in this rule and will be finalized as of the date the CY 2010 PFS final rule with comment period goes on display at the Office of the Federal Register. No changes (that is, additions or deletions of measures) will be made after publication of the CY 2010 PFS final rule with comment period. However, as was the case for 2008 and 2009, we may make modifications or refinements, such as revisions to measures titles and code additions, corrections, or revisions to the detailed specifications for the 2010 measures until the beginning of the reporting period. Such specification modifications may be made through the last day preceding the beginning of the reporting period. The 2010 measures specifications for individual quality

measures will be available on the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI when they are sufficiently developed or finalized. We are targeting finalization and publication of the detailed specifications for all 2010 PQRI measures on the PQRI section of the CMS Web site by November 15, 2009 and will, in no event, publish these specifications later than December 31, 2009. The detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable.

For 2010, we are proposing that final PQRI quality measures will be selected from 153 of the 2009 PQRI measures and 149 measure suggestions received in response to the February 2009 invitation to submit suggestions for measures and measures groups for possible inclusion in the 2010 PORI (that is, the "Call for 2010 Measure Suggestions"). We propose to include a total of 168 measures (this includes both individual measures and measures that are part of a proposed 2010 measures group) on which individual eligible professionals can report for the 2010 PQRI. The individual PQRI quality measures proposed for the 2010 PQRI are listed in Tables 17 through 20 and fall into four broad categories as set forth below in this section. The four categories are the following:

- (1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-Based Reporting;
- (2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-based Reporting Only;
- (3) New Individual Quality Measures Proposed for 2010; and
- (4) Proposed 2010 Measures Available for EHR-based Reporting.

In addition, we propose 13 measures groups for 2010. The measures proposed for inclusion in each of the proposed 2010 measures groups are listed in Tables 21 through 33.

(1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registrybased Reporting

After careful consideration of 2009 PQRI measures, we propose to retire 7 measures because they did not meet one or more of the considerations for selection of proposed 2010 measures discussed in section II.G.2.h. of this proposed rule. The measures, including their Measure Number and Measure Title, and the specific reason(s) we are using as the basis for our proposal to retire the measures are identified in Table 16.

Table 16—2009 PQRI Quality Measures Not Proposed for Inclusion in the 2010 PQRI

Measure no.	Measure title	Reason for retirement
11	Stroke and Stroke Rehabilitation: Carotid Imagining Reporting Stroke and Stroke Rehabilitation: Tissue Plasminogen Acti-	Analytically challenging / Replaced with another measure. Analytically challenging / Replaced with another measure.
94 95 143 144	vator. Otitis Media with Effusion (OME): Diagnostic Evaluation Otitis Media with Effusion (OME): Hearing Test Oncology: Medical and Radiation—Pain Intensity Quantified Oncology: Medical and Radiation—Plan of Care for Pain	Lack of significant reporting. Lack of significant reporting. Analytically challenging. Analytically challenging. Declined for NQF Endorsement.

We propose to include in the 2010 PQRI quality measure set 116 of the 2009 PQRI measures, which would be available for either claims-based reporting or registry-based reporting as individual quality measures. We note that one of these proposed measures, Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility, is reportable through the registry-based reporting mechanism only in the 2009 PQRI. However, for the 2010 PQRI, we propose to make this measure available for either claimsbased reporting or registry-based reporting. For the 2009 PQRI, registries have reported difficulty capturing the

required information since the measure requires the inpatient discharge to be correlated to the outpatient visit. Therefore, for the 2010 PQRI we propose to make this measure available for both claims-based and registry-based reporting.

These 116 proposed measures do not include any measures that are proposed to be included as part of the 2010 Back Pain measures group. Similar to the 2009 PQRI, we propose that any 2010 PQRI measure that is included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The 116 individual 2009 PQRI measures proposed for inclusion in the 2010 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 17, along with the name of the measure's developer/owner, their NQF endorsement status as of May 1, 2009, and their AQA adoption status as of January 31, 2009. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different

measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the proposed measures listed in Table 17 can be found in the "2009 PQRI Quality Measures List," which is available on the Measures and Codes page of the PQRI section of the CMS Web site at http://www.cms.hhs.gov/PQRI. The 2009 measures that are proposed to be available for registry-based reporting only for the 2010 PQRI are discussed and identified in section II.G.2.i.(2) of this proposed rule.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING

	LITHER CLAIMS-DASED IN			TIEI OTTING
Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Perscribed for Patients with CAD.	Yes	Yes	AMA-PCPI.
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD.	Yes	Yes	NCQA.
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	Yes	Yes	AMA-PCPI/NCQA.
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	Yes	Yes	AMA-PCPI/NCQA.
14	Age-Related macular Degeneration (AMD): Dilated Macular Examination.	Yes	Yes	
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	Yes	Yes	AMA-PCPI/NCQA.
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabe- tes Care.	Yes	Yes	AMA-PCPI/NCQA.
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA-PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA-PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	Yes	Yes	AMA-PCPI/NCQA.
23	Perioperative Care: Venous Thrombo- embolism (VTE) Prophylaxis (When Indi- cated in ALL Patients).	Yes	Yes	AMA-PCPI/NCQA.
24	Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture.	Yes	Yes	AMA-PCPI/NCQA.
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI).	Yes	Yes	AMA-PCPI/NCQA.
30	1	Yes	Yes	AMA-PCPI/NCQA.
31	l	Yes	Yes	AMA-PCPI/NCQA.
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy.	Yes	Yes	AMA-PCPI/NCQA.
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia.	Yes	Yes	AMA-PCPI/NCQA.
36	Stroke and Stroke Rehabilitation: Consideration for Rehabilitation Services.	Yes	Yes	AMA-PCPI/NCQA.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA-PCPI/NCQA.
40	Osteoporosis: Management Following Fracture.	Yes	Yes	AMA-PCPI/NCQA.
41	Osteoporosis: Pharmacologic Therapy	Yes	Yes	AMA-PCPI/NCQA.
43	Coronary Artery Bypass Graft (CABG): Use	Yes	Yes	Society of Thoracic Surgeons (STS).
	of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.			

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Meas	sure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
14		Coronary Artery Bypass Graft (CABG): Pre- operative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
45		Perioperative Care: Discontinuation of Prophylactic Antiobitics (Cardiac Procedures).	Yes	Yes	AMA-PCPI/NCQA.
46		Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility.	Yes	Yes	AMA-PCPI/NCQA.
47		Advance Care Plan	Yes	Yes	AMA-PCPI/NCQA.
48		Urinary Incontinence: Assessment of Pres-	Yes	Yes	AMA-PCPI/NCQA.
		ence or Absence of Urinary Incontinence in Women Aged 6 Years and Older.			
49		Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA-PCPI/NCQA.
50		Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA-PCPI/NCQA.
51		Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation.	Yes	No	AMA-PCPI.
52		Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy.	Yes	No	AMA-PCPI.
		Asthma: Pharmacologic Therapy	Yes	Yes	
54		12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain.	Yes	Yes	AMA-PCPI/NCQA.
55		12-Lead Electrocardiogram (ECG) Performed for Syncope.	Yes	Yes	AMA-PCPI/NCQA.
56		Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA-PCPI/NCQA.
57		Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	Yes	Yes	AMA-PCPI/NCQA.
58		Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA-PCPI/NCQA.
59		Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA-PCPI/NCQA.
		Asthma: Asthma Assessment	Yes	Yes	AMA-PCPI. NCQA.
66		Appropriate Testing for Children with Pharyngitis.	Yes	Yes	NCQA.
67		Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.	Yes	Yes	AMA-PCPI/American Society of Hema tology (ASH).
68		Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Re-	Yes	Yes	AMA-PCPI/ASH.
69		ceiving Erythropoietin Therapy. Multiple Myeloma: Treatment with Bisphosphonates.	Yes	Yes	AMA-PCPI/ASH.
70		Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry.	Yes	Yes	AMA-PCPI/ASH.
71		Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	Yes	Yes	AMA–PCPI/American Society of Clinical On cology (ASCO)/National Comprehensive Cancer Network (NCCN).
72		Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	Yes	Yes	AMA-PCPI/ASCO/NCCN.
76		Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol.	Yes	Yes	AMA-PCPI.
79		End Stage Renal Disease (ESRD): Influenza Immunization with Patients in ESRD.	Yes	Yes	AMA-PCPI.
34		Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA-PCPI.
35		Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA-PCPI.
		Hepatitis C: Antiviral Treatment Prescribed Hepatitis C: HCV Ribonucleic Acid (RNA)	Yes	Yes	AMA-PCPI. AMA-PCPI.
39		Testing at Week 12 of Treatment. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA-PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA-PCPI.
91 92	Acute Otitis Externa (ACE): Topical Therapy Acute Otitis Externa (ACE): Pain Assess- ment.	No	Yes	AMA-PCPI. AMA-PCPI.
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.	No	Yes	AMA-PCPI.
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade.	Yes	Yes	AMA–PCPI/College of American Pathologists (CAP).
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grace.	Yes	Yes	AMA-PCPI/CAP.
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients.	Yes	Yes	AMA-PCPI.
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients.	Yes	Yes	AMA-PCPI.
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy.	Yes	Yes	AMA-PCPI.
106	Major Depressive Disorder (MDD): Diagnostic Evaluation.	Yes	No	AMA-PCPI.
107	Major Depressive Disorder (MDD): Suicide Risk Assessment.	Yes	No	AMA-PCPI.
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
109	Osteoarthritis: Function and Pain Assessment.	Yes	No	AMA-PCPI.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old.	Yes	No	AMA-PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112		Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA-PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA-PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA-PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA-PCPI.
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/Quality Insights of Pennsylvania (QIP).

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neuro- logical Evaluation.	Yes	Yes	American Podiatric Medical Association (APMA).
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear.	Yes	Yes	APMA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
130	Documentation and Verification of Current Medications in the Medical Record.	Yes	Yes	CMS/QIP.
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up.	Yes	Yes	CMS/QIP.
134	Screening for Clinical Depression and Follow-Up Plan.	Yes	Yes	CMS/QIP.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	Yes	Yes	AMA-PCPI.
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.	No	Yes	AMA-PCPI/NCQA.
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	Yes	Yes	AMA-PCPI.
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy.	Yes	Yes	AMA-PCPI/NCQA.
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mam- mography Screening.	Yes	Yes	AMA-PCPI/NCQA.
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy.	Yes	Yes	AMA-PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	Yes	Yes	AMA-PCPI.
154	Falls: Risk Assessment	No	Yes	AMA-PCPI/NCQA.
155 156	Palls: Plan of Care	No Yes	Yes	AMA-PCPI/NCQA. AMA-PCPI.
157	Tissues. Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection.	Yes	Yes	STS.
158	Endarterectomy: Use of Patch During Conventional Endarterectomy.	Yes	No	Society of Vascular Surgeons (SVS).
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
172	Hemodialysis Vascular Access Decision- Making by Surgeon to Maximize Place- ment of Autogenous Arterial Venous (AV) Fistula.	Yes	No	SVS.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening.	No	Yes	AMA-PCPI.
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization.	No	Yes	AMA-PCPI.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA-PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA-PCPI/NCQA.
178	Rhuematoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA-PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA-PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA-PCPI/NCQA.
181	Elder Maltreatment Screen and Follow-Up Plan.	No	Yes	CMS/QIP.
182	Functional Outcome Assessment in Chiropractic Care.	No	Yes	CMS/QIP.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA-PCPI.
184	Hepatitis C: Hepatatis B Vaccination in Patients with HCV.	Yes	Yes	AMA-PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR
EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoid- ance of Inappropriate Use.	No	Yes	AMA-PCPI/NCQA.
186		No	Yes	AMA-PCPI/NCQA.

Please note that detailed measure specifications for 2009 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. The 2010 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-Based Reporting Only

In the 2008 PQRI, all 2008 PQRI quality measures were reportable through either claims-based reporting or registry-based reporting. In the CY 2009 PFS final rule with comment period (73 FR 69833), we noted that some measures are not as conducive to claims-based reporting and indicated that 18 of the 2009 PQRI quality measures are not currently reportable through claims-based reporting due to their complexity. Instead, these 18

measures must be reported through a qualified PQRI registry for the 2009 PQRI. We referred to these measures as "registry-only" measures. As discussed further in section II.G.2.d. of this proposed rule, registry-based reporting overcomes some of the limitations of claims-based reporting.

For the 2010 PQRI, we again propose to include registry-only individual measures. For 2010, we propose to select 26 registry-only individual measures from the 2009 PQRI.

As we noted previously, 1 measure (measure #46) that was a registry-only measure for the 2009 PQRI is now proposed to be available for either claims-based reporting or registry-based reporting in the 2010 PQRI. Therefore, this measure is not included among these 26 proposed registry-only individual measures. These 26 proposed measures do include 9 measures that are available for either claims-based reporting or registry-based reporting in the 2009 PQRI and are now proposed to be included in the 2010 PQRI as registry-only measures. We are proposing to make more 2009 measures registry-only to relieve some analytical difficulties encountered during the 2009 PORI.

Ålthough we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2010. We rely

on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2010, then an eligible professional would not be able to report that particular measure type. We invite comments on our proposal to increase the number of registry-only measures for the 2010 PQRI.

The Measure Number and Measure Title for these proposed registry-only measures are listed in Table 18 along with the name of each measure's developer, the measure's NQF endorsement status as of May 1, 2009, and the measure's AQA adoption status as of January 31, 2009. A description of the proposed measures listed in Table 18 can be found in the "2009 PQRI Quality Measures List," which is available on the Measures and Codes page of the PQRI section of the CMS Web site at http://www.cms.hhs.gov/ PORI. Measures that were available for either claims-based reporting or registrybased reporting in the 2009 PQRI but are proposed to be available for registrybased reporting only in the 2010 PQRI are identified by an asterisk (*) in Table

TABLE 18—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA-PCPI.
7	Coronary Artery Disease (CAD): Beta- Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA-PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA-PCPI.

Table 18—Proposed 2010 Measures Selected From the 2009 PQRI Quality Measure Set Available for Registry-Based Reporting Only—Continued

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	Yes	Yes	AMA-PCPI/NCQA.
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	Yes	Yes	AMA-PCPI.
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	Yes	Yes	AMA-PCPI.
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia*.	Yes	Yes	AMA-PCPI.
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)*.	Yes	No	AMA-PCPI.
136	Melanoma: Follow-Up Aspects of Care*	No	Yes	AMA-PCPI/NCQA.
137	Melanoma: Continuity of Care—Recall System*.	No	Yes	AMA-PCPI/NCQA.
138	Melanoma: Coordination of Care*	No	Yes	AMA-PCPI/NCQA.
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intra- ocular Lens (IOL) Placement*.	No	Yes	AMA-PCPI/NCQA.
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care*.	No	Yes	AMA-PCPI/NCQA.
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA-PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA-PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA-PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	No	AMA-PCPI/NCQA.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	Yes	Yes	STS.
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	No	Yes	AMA-PCPI.

^{*} Individual 2009 PQRI measures that were available for both claims-based and registry-based reporting but proposed to be available for registry-based reporting only for the 2010 PQRI.

Please note that detailed measure specifications for 2009 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. Therefore, the 2010 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality

measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the

CMS Web site on or before December 31, 2009.

(3) New Individual Quality Measures Proposed for 2010

We propose to include in the 2010 PQRI quality measure set 22 measures that were not included in the 2009 PQRI quality measures provided that each measure obtains NQF endorsement by July 1, 2009 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2009. Besides having NQF endorsement, the development of a measure is considered complete for the purposes of the 2010 PQRI if by August 15, 2009—(1) The final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for

the measure have been established and will be effective for CMS claims data submission on or before January 1, 2010. The titles of these proposed additional, or new, measures are listed in Table 19 along with the name of the measure developer and the proposed reporting mechanism (that is, whether the measure is proposed to be reportable using claims, registries, or both). For these 22 proposed measures, a PQRI Measure Number will be assigned to a measure if and when the measure is

included in the final set of 2010 PQRI measures.

Due to the complexity of their measure specifications, we propose that 16 of these 22 measures would be available as registry-only measures for the 2010 PQRI. We do not believe that these 16 measures are conducive to the claims-based reporting mechanism. The remaining 6 measures would be available for reporting through either claims-based reporting or registry-based reporting.

TABLE 19—New Individual Quality Measures Proposed for 2010

511			51.15 1 1.15 1 5515 1 51 1 1 0 1 5	
Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Thrombolytic Therapy Administered	Yes	No	American Heart Association (AHA)/ American Stroke Association (ASA).	Registry.
Referral for Otologic Evaluation for Patients with Visible Congenital or Traumatic Deformity of the Ear.	Pending NQF re- view.	No	Audiology Quality Consortium (AQC)	Claims, Registry.
Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery.	Pending NQF re- view.	Yes	American Academy of Ophthalmology (AAO)/AMA-PCPI/NCQA.	Registry.
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Pending NQF review.	Yes	AAO/AMA-PCPI/NCQA	Registry.
Perioperative Temperature Management.	Yes	Yes	AMA-PCPI	Claims, Registry.
Cancer Stage Documented	Yes	Yes	AMA-PCPI	Claims, Registry.
Stenosis Measurement in Carotid Imaging Studies.	Yes	Yes	American College of Radiology (ACR)/ AMA-PCPI/NCQA.	Claims, Registry.
Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	No	ACC/AHA/AMA-PCPI	Registry.
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Choles- terol.	Yes	No	ACC/AHA/AMA-PCPI	Registry.
Heart Failure (HF): Left Ventricular Function Assessment.	Yes	No	ACC/AHA/AMA-PCPI	Registry.
Heart Failure (HF): Patient Education	Yes	No	ACC/AHA/AMA-PCPI	Registry.
Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	No	ACC/AHA/AMA-PCPI	Registry.
Blood Pressure Management: Control	Yes	No	NCQA	Registry.
Complete Lipid Profile	Yes	No	NCQA	Registry.
Cholesterol Count	Yes	No	NCQA	Registry.
Use of Aspirin or Another Anti-Thrombotic.	Yes	No	NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Chlamydia and Gonorrhea Screenings.	Yes	No	AMA-PCPI/NCQA	Registry.
HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	No	AMA-PCPI/NCQA	Registry.
HIV/AIDS: Screening for Injection Drug Use.	Yes	No	AMA-PCPI/NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA-PCPI/NCQA	Registry.

(4) Proposed 2010 Individual Quality Measures Available for EHR-Based Reporting

As discussed in section II.G.2.d.(3) of this proposed rule, we propose to accept PQRI data from EHRs for a limited subset of the proposed 2010 PQRI quality measures, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. The 10 proposed 2010 PQRI quality measures on which we propose to accept clinical quality data extracted from EHRs are identified in Table 20. We propose to make these measures available for electronic submission via an EHR because these measures target preventive care or common chronic

conditions. In addition, 4 of these proposed measures overlap with measures used in the Medicare Quality Improvement Organization program's 9th Statement of Work. Finally, it is much less burdensome for an eligible professional to report Measure #124, which assesses adoption and use of EHRs, through an EHR than through claims.

TABLE 20—PROPOSED 2010 MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.			NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.			NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).		Yes	AMA-PCPI
7	Coronary Artery Disease (CAD): Beta- Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA-PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/QIP

(5) Measures Proposed for Inclusion in 2010 Measures Groups

We propose to retain the 7 2009 PQRI measures groups for the 2010 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; and (7) Back Pain. These measures groups were selected for inclusion in the 2010 PQRI because they each contain at least 4 PQRI quality measures that share a common denominator definition.

Except for the CABG measures group, all 2009 measures groups are reportable either through claims-based reporting or registry-based reporting. The CABG measures group, for the 2009 PQRI, is reportable through the registry-based reporting mechanism only since some measures included in the 2009 CABG measures group are registry-only individual PQRI measures. For this reason, we propose the CABG measures group would be reportable through the registry-based reporting mechanism

only for 2010 while the remaining 6 2009 PQRI measures groups would be reportable through either claims-based reporting or registry-based reporting for the 2010 PQRI.

Except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group are reportable either as individual measures or as part of a measures group. As stated in the CY 2009 PFS final rule with comment period (73 FR 69843 through 69844), as individual measures, the measures in the Back Pain measures group are too basic. However, taken together they are meaningful indicators of quality of care for back pain. For this reason, for the 2010 PQRI, we propose that except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group that we propose to carry forward for the 2010 PQRI would be reportable either as individual measures or as part of a measures group.

The measures proposed for inclusion in the 2010 measures groups that are based on the measures groups from 2009 are identified in Tables 21 through 27. Some measures proposed for inclusion in some of these measures groups for 2010 were not included in the measures groups in 2009. The 2009 measures proposed for inclusion in a 2010 measures group that were not included in the measures group for 2009 are identified with an asterisk (*).

As with measures group reporting in the 2008 and 2009 PQRI, we propose that each eligible professional electing to report a group of measures for 2010 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by applicable reporting criteria (described above in section II.G.2.f. of this proposed rule). The individual measures included in the final 2010 PQRI measures groups will be limited to

those measures which will be identified $\,$ comment period as final 2010 PQRI in the CY 2010 PFS final rule with $\,$ measures

TABLE 21—MEASURES PROPOSED FOR 2010 DIABETES MELLITUS MEASURES GROUP

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam*	Yes	No	NCQA.

^{*}This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

TABLE 22—MEASURES PROPOSED FOR 2010 CKD MEASURES GROUP

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA-PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA-PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA-PCPI.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	No	Yes	AMA-PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	No	Yes	AMA-PCPI.

TABLE 23—MEASURES PROPOSED FOR 2010 PREVENTIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA-PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA-PCPI/NCQA.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA-PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA-PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening*.	No	Yes	AMA-PCPI.

^{*}This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

Table 24—Measures Proposed for 2010 CABG Measures Group +

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Yes	Yes	Society of Thoracic Surgeons (STS).
44	Coronary Artery Bypass Graft (ČABG): Pre- operative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169		Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171		Yes	Yes	STS.

⁺ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 25—MEASURES PROPOSED FOR 2010 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
108	Rheumatoid Arthritis (RA): Disease Modi- fying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA-PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA-PCPI/NCQA.
178	Rheumatoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA-PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA-PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA-PCPI/NCQA.

TABLE 26—MEASURES PROPOSED FOR 2010 PERIOPERATIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA-PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA-PCPI/NCQA.
22	Perioperative Care: Discontinuation of Pro- phylactic Antibiotics (Non-Cardiac Proce- dures).	Yes	Yes	AMA-PCPI/NCQA.
23	Perioperative Care: Venous Thrombo- embolism (VTE) Prophylaxis (When Indi- cated in ALL Patients).	Yes	Yes	AMA-PCPI/NCQA.

TABLE 27—MEASURES	DRODOCED FOR	2010 BACK	DAIN MEACHDEC	CDOLID
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Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/ 31/09	Measure developer
149	Back Pain: Initial Visit	Yes	Yes	NCQA.
150		Yes	Yes	NCQA.

In addition to the 7 measures groups that we propose to retain from the 2009 PQRI, we propose 6 new measures groups for the 2010 PQRI, for a total of 13 CY 2010 measures groups. The 6 new measures groups proposed for the 2010 PQRI are: (1) Coronary Artery Disease (CAD); (2) Heart Failure (HF); (3) Ischemic Vascular Disease (IVD): (4) Hepatitis C; (5) Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS); and (6) Community Acquired Pneumonia (CAP). Many of the 6 new measures groups proposed for 2010 contain proposed new registry-only measures, which would make them reportable through registry-based reporting only. Therefore, only 8 proposed 2010 measures groups would be reportable through either claimsbased reporting or registry-based reporting: Diabetes Mellitus; CKD; Preventive Care; Perioperative Care;

Rheumatoid Arthritis; Back Pain; Hepatitis C; and Community Acquired Pneumonia. We invite comments on our proposal to limit claims-based reporting of measures groups in 2010.

New measures groups are proposed for the 2010 PQRI in order to address gaps in quality reporting and are those that have a high impact on HHS and CMS priority topics for improved quality and efficiency for Medicare beneficiaries (such as prevention, chronic conditions, high cost/high volume conditions, improved care coordination, improved efficiency, improved patient and family experience of care, and effective management of acute and chronic episodes of care). Groups were identified in topical areas where: (1) 4 or more proposed 2010 measures are available; (2) the measures are NQF endorsed; and (3) they address a gap in quality reporting. The measures proposed for inclusion in these new

2010 measures groups are identified in Tables 28 through 33.

Some measures proposed for inclusion in these 6 measures group are current 2009 individual PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 28 through 33. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PORI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded by "TBD") in Tables 28 through 33 have never been part of a PQRI measure set until being proposed now. A number will be assigned to such measures if we include them in the final set of 2010 PQRI measures groups.

TABLE 28—MEASURES PROPOSED FOR 2010 CAD MEASURES GROUP +

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Pa- tients with CAD.	Yes	Yes	AMA-PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA-PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	Yes	ACC/AHA/AMA-PCPI.
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA-PCPI.

⁺ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 29—MEASURES PROPOSED FOR 2010 HF MEASURES GROUP +

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).		Yes	AMA-PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA-PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA-PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.

Table 29—Measures Proposed for 2010 HF Measures Group +—Continued

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	Heart Failure (HF): Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA-PCPI.
	Heart Failure (HF): Patient Education			
IBD	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA=PCPI.

⁺ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 30—MEASURES PROPOSED FOR 2010 IVD MEASURES GROUP +

Measure number	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure Developer
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA-PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Blood Pressure Management: Control	Yes	No	NCQA.
TBD	Complete Lipid Profile	Yes	No	NCQA.
TBD	Cholesterol Control	Yes	No	NCQA.
TBD	Use of Aspirin or Another Anti-Thrombotic	Yes	No	NCQA.

⁺ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 31—MEASURES PROPOSED FOR 2010 HEPATITIS C MEASURES GROUP

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA-PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA-PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	Yes	Yes	AMA-PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	Yes	Yes	AMA-PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA-PCPI.
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA-PCPI.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA-PCPI.
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV.	Yes	Yes	AMA-PCPI.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP +

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA-PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA-PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA-PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	Yes	AMA-PCPI/NCQA.
TBD	HIV/AIDS: Sexually Transmitted Diseases— Chlamydia and Gonorrhea Screenings.	Yes	Yes	AMA-PCPI/NCQA.
TBD	HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	Yes	AMA-PCPI/NCQA.
TBD	HIV/AIDS: Screening for Injection Drug Use	Yes	Yes	AMA-PCPI/NCQA.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP +—Continued

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA-PCPI/NCQA.

⁺ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 33—MEASURES PROPOSED FOR 2010 COMMUNITY-ACQUIRED PNEUMONIA MEASURES GROUP

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
56	Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA-PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.			
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA-PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA-PCPI/NCQA.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2010 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI by no later than December 31, 2008.

Additionally, the detailed measure specifications and instructions for submitting data on those proposed 2010 measures groups that were also included as 2009 PQRI measures groups may be updated or modified prior to 2010. Therefore, the 2010 PORI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2009. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

(6) Request for Public Comment on Measure Suggestions for Future PQRI Quality Measure Sets

As stated above, on February 1, 2009, we posted a "Call for 2010 PQRI Measure Suggestions" on the PQRI section of the CMS Web site at http://

www.cms.hhs.gov/PQRI. The "Call for 2010 PQRI Measure Suggestions" invited the public to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of existing measures groups) for consideration for possible inclusion in the proposed set of quality measure for use in the 2010 PQRI. To facilitate our evaluation of the suggested measures, we asked individuals or organizations submitting suggestions to provide us with the following information:

- Requestor contact information, such as name and title, organization/practice name, phone number and e-mail address;
 - Measure title;
 - Measure description;
 - Measure owner/developer;
- NQF endorsement status, including the date of endorsement or anticipated endorsement (if not NQF-endorsed) and type of endorsement (for example, timelimited endorsement);
- AQA adoption status, including date of AQA adoption or anticipated AQA adoption;
- Preferred PQRI reporting option for the suggested measure(s) (that is, claims, registry, registry-only, measures group, measures group only, EHRs); and
- The measure specifications. In lieu of posting a call for 2011 PQRI measure suggestions on the PQRI section of the CMS Web site in 2010, we invite commenters to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of proposed 2010 measures groups) for

consideration for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI. When submitting suggestions for future PQRI quality measure sets as part of the comment period for this proposed rule, commenters should submit all the information requested above for the "Call for 2010 PQRI Measure Suggestions."

Please note that suggesting individual measures or measures for a new or proposed measures group does not mean that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the 2011 PQRI. We will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, we will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

j. Proposed 2010 PQRI Quality Measures for Physician Groups Selected to Participate in the Group Practice Reporting Option

As discussed in section II.G.2.g. of this proposed rule, we propose that physician groups selected to participate in the 2010 PQRI group practice reporting option would be required to report on 26 measures. These measures are NQF-endorsed measures currently collected as part of the PGP and/or MCMP demonstrations and are identified in Table 34. To the extent that a measure is an existing PQRI measure, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the Measure Number column of the table, then the

measure is not an existing PQRI measure and will be added to the 2010

PQRI for purposes of the group practice reporting option.

TABLE 34—MEASURES PROPOSED FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2010 PQRI GROUP PRACTICE REPORTING OPTION

Measure No.	Measure title	NQF endorse- ment status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein Control.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control.	Yes	No	NCQA.
5	Heart Failure: ACE Inhibitor or ARB Therapy for LVSD.	Yes	Yes	AMA-PCPI.
6	Coronary Artery Disease: Oral Anti-platelet Therapy.	Yes	Yes	AMA-PCPI.
7	Coronary Artery Disease:Beta-blocker Therapy for CAD Patients with Prior MI.	Yes	Yes	AMA-PCPI.
8	Heart Failure: Beta-blocker Therapy for LVSD.	Yes	Yes	AMA-PCPI.
110	Preventive Care: Influenza Vaccination for Patients > 50 years.	Yes	No	AMA-PCPI.
111	Preventive Care: Pneumonia Vaccination for Patients 65+ years.	Yes	Yes	NCQA.
112	Preventive Care: Screening Mammography	Yes	Yes	NCQA.
113	Preventive Care: Screening Colorectal Cancer.	Yes	Yes	NCQA/AMA-PCPI.
117	Diabetes Mellitus: Dilated Eye Exam	Yes	Yes	NCQA.
118	Coronary Artery Disease: ACE/ARB for Patients with CAD and Diabetes and/or LVSD.	Yes	No	AMA-PCPI.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
TBD	Diabetes Mellitus: Hemoglobin A1c Testing	Yes	No	NCQA.
TBD	Diabetes Mellitus: Lipid Profile	Yes	No	NCQA.
TBD	Heart Failure: Left Ventricular Function Testing.	Yes	Yes	CMS.
TBD	Heart Failure: Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA-PCPI.
TBD	Heart Failure: Weight Measurement	Yes	No	ACC/AHA/AMA-PCPI.
TBD	Heart Failure: Patient Education	Yes	Yes	ACC/AHA/AMA-PCPI.
TBD	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA-PCPI.
TBD	Coronary Artery Disease: Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA-PCPI.
TBD	Preventive Care: Blood Pressure Management.	Yes	No	ACC/AHA/AMA-PCPI.
TBD	Hypertension: Blood Pressure Control	Yes	No	CMS/NCQA.
TBD	Hypertension: Plan of Care	Yes	No	ACC/AHA/AMA-PCPI.
	71 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -			

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers as defined and discussed further in section II.G.5. of this proposed rule. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule

with comment period (73 FR 69846 through 69847) our intent, in 2010, to enhance the current Physician and Other Health Care Professionals directory at http://www.medicare.gov with the names of eligible professionals that satisfactorily submit quality data for the 2009 PQRI. In December 2008, we listed, by State, the names of eligible professionals who participated in the 2007 PQRI on the Physician and Other Health Care Professionals Directory.

As required by section 1848(m)(5)(G) of the Act, we intend to make public the names of eligible professionals and group practices that satisfactorily

submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of eligible professionals, on the Physician and Other Health Care Professionals Directory, we propose to post the names of eligible professionals who: (1) Submit data on the 2010 PQRI quality measures through one of the

reporting mechanisms available for the 2010 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2010 PQRI described above in section II.G.2.e. and II.G.2.f., respectively of this proposed rule; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Submit data on the 2010 PQRI quality measures through the proposed group practice reporting option described in section II.G.2.g. of this proposed rule; (2) meet the proposed criteria for satisfactory reporting under the group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for group

In addition to posting the information required by section 1848(m)(5)(G) of the Act, for those group practices that are selected to participate in PQRI under the group practice reporting option, we also propose to make the group practices' PQRI performance rates publicly available, for each of the measures. As we stated in the CY 2009 PFS proposed rule (73 FR 38574 through 38575), it is our goal to make the quality of care for services furnished to Medicare beneficiaries publicly available by making physician quality measure performance rates, either at the individual practitioner level or physician group level, publicly available. While we currently have Web pages at http://www.medicare.gov for the public reporting of performance results on standardized quality measures for hospitals (Hospital Compare), dialysis facilities (Dialysis Facility Compare), nursing homes (Nursing Home Compare), and home health facilities (Home Health Compare), we do not have a similar Compare Web site for information on the quality of care for services furnished by physicians and other professionals to Medicare beneficiaries.

Public reporting of group practices' PQRI performance results at the group practice level would allow us to move toward our goal of making information on physician performance publicly available. We believe that the way we have proposed to design the group practice reporting option (see section II.G.2.g. of this proposed rule) facilitates public reporting of the groups'

performance results. Group practices participating in the group practice reporting option would have already agreed in advance to have their performance results publicly reported. All groups participating in the group practice reporting option would be reporting on identical measures, which facilitate comparison of the results across groups. In addition, as a result of the proposed reporting criteria, no performance results would be calculated based on small denominator sizes. Finally, because we intend to modify the data collection tool will provide each group practice with numerator, denominator, and performance rates for each measure at the time of tool submission, the group practice will have had an opportunity to review their performance results before they are made public.

In making performance rates for group practices publicly available, we will attribute the group practice's performance to the entire group. We will not post information with respect to the performance of individual physicians or other eligible professionals associated with the group. However, we may identify the individual eligible professionals who were associated with the group during the reporting period. We invite comments regarding our proposal to publicly report group practices' PQRI performance results.

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

a. Statutory Authority

As required under section 1848(n) of the Act, as added by section 131(c) of the MIPPA, we established and implemented by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. Section 1848(n) of the Act authorizes us, as we determine appropriate, to include information on the quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. Although we initially called this effort the Physician Resource Use Feedback Program, we are renaming this initiative the "Physician Resource Use Measurement and Reporting Program" (hereinafter referred to as "Program").

b. Background

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69866), the Program would consist of multiple phases. We included a summary of the activities of phase I of the Program in the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869). In addition to discussing phase I of the Program, we also highlighted the activities of several other initiatives, including Medicare Value-Based Purchasing (VBP) programs and demonstrations and related activities undertaken by the MedPAC and the Government Accountability Office (GAO). We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a detailed discussion of these activities.

In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869), we finalized, on an interim basis, the following parameters for phase I of the Program: (1) Use of both per capita and episode of care methodologies for resource use measurement; (2) cost of service category analysis (for example, imaging services or inpatient admissions); (3) use of 4 calendar years of claims data; (4) focus on high cost and/or high volume conditions; (5) reporting to physician specialties relevant to the selected focal conditions; (6) focus on physicians practicing in certain geographic areas, and (7) low, median, and high cost benchmarks. We intend to finalize these parameters in the CY 2010 PFS final rule with comment period.

c. Summary of Comments From the CY 2009 PFS Final Rule With Comment Period

Section 1848(n)(1)(B) of the Act requires that the Program measures resources based on the following: (1) An episode basis; (2) a per capita basis; or (3) both an episode and a per capita basis. We solicited public comments on the use of each of these measurement methodologies (73 FR 69868).

Comment: Commenters were in favor of using both the per capita and the per episode measurement methodologies.

Response: We agree with commenters that both the per capita and per episode methodologies are appropriate measures of cost for the Program. Each methodology offers distinct advantages. For a further discussion regarding the advantages, we refer readers to CMS' Medicare Resource Use Measurement Plan Web site at http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/ResourceUse_Roadmap_OEA_1-15_508.pdf. We intend to finalize both

methodologies as options for use in future phases of the Program in the CY 2010 PFS final rule with comment period.

In phase I of the Program, we included cost of service (COS) category information from aggregated Medicare FFS claims data. We solicited public comment on which COS categories are most meaningful and actionable (73 FR 69868).

Comment: Commenters were overwhelmingly in favor of including E/M services and imaging services as meaningful and actionable COS categories. Further, commenters supported including laboratory services, outpatient services, procedures, and post-acute services as COS categories. No commenters raised specific categories that should be excluded.

Response: We appreciate the comments in support of the COS category analysis. We intend to finalize the option to include information on all of these COS categories in future phases of the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(3) of the Act requires that, to the extent practicable, the data for the reports shall be based on the most recent data available. In phase I of the Physician Resource Use Feedback Program, we used Medicare FFS claims data from CY 2004 through CY 2007. We solicited public comment on this approach (73 FR 69868).

Comment: The majority of commenters stated that 3 calendar years of data is sufficient for calculating resource use measures. Further, commenters emphasized, to the extent practicable, CMS should use the most recent three years of data available for the Program.

Response: We agree with commenters that 3 years of Medicare FFS claims data are sufficient for calculating resource use measures. We intend to finalize the use of the most recent 3 years of data available for the Program in the CY 2010 PFS final rule with comment period.

Under section 1848(n)(4)(B) of the Act, the Secretary may focus the Program as appropriate, including focusing on physicians who treat conditions that are high cost, high volume, or both. We finalized on an interim basis for phase I of the Program, the following conditions: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; and (8) urinary tract infection (73 FR 69868). We solicited public comments on the

use of these high cost/high volume conditions (73 FR 69868).

Comment: Commenters strongly supported these conditions as appropriate for measuring the resources furnished to Medicare beneficiaries. In addition, several commenters suggested that we include diabetes among the priority conditions for the Program.

Response: We agree with commenters that diabetes is an important condition to capture in the Program. We intend to finalize the option to include: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; (8) urinary tract infection; and (9) diabetes, in the Program in the CY 2010 PFS final rule with comment period.

Under section $18\overline{4}8(n)(4)(A)$ of the Act, we are permitted to focus reporting on physician specialties that account for a certain percentage of spending for physicians' services. Based on the high cost and high volume conditions selected above, we included the following physician specialties in phase I of the Program: General internal medicine, family practice, gastroenterology, cardiology, general surgery, infectious disease, neurology, orthopedic surgery, physical medicine and rehabilitation, pulmonology, and urology (73 FR 69868). We solicited public comments on the inclusion of these physician specialties (73 FR 69868).

Comment: Commenters supported including all of the physician specialties listed above as appropriate for measurement and reporting based on the selected conditions.

Response: We agree with commenters that the physician specialties listed above should be included in the Program. We intend to finalize the option to include these physician specialties in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(D) of the Act permits us to focus the Program on physicians practicing in certain geographic areas. In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) we referenced two geographic sites (Baltimore, MD and Boston, MA) for phase I of the Program, which we generally selected based on close proximity to the CMS central office and due to high per capita Medicare costs, respectively. Since the final rule was published, we have also mailed reports to physicians in the following sites:

Greenville, SC;

- Indianapolis, IN;
- Northern New Jersey;
- Orange County, CA;
- Seattle, WA;
- · Syracuse, NY;
- Boston, MA;
- Cleveland, OH;
- East Lansing, MI;
- Little Rock, AR;
- Miami, FL; and
- Phoenix, AZ.

Comment: Commenters were in favor of including a limited number of sites representing a wide range of geographic locations to facilitate a phased implementation. No commenters submitted specific areas that should be excluded.

Response: We appreciate the comments in support of including a limited number of sites. We intend to continue to include the geographic sites listed above, and identify a limited number of new locations, in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(C) of the Act also permits us to focus the program on physicians who use a high amount of resources compared to other physicians. The resource use reports disseminated in phase I of the Program defined peer groups of physicians by focusing on one condition, one specialty, and one of the geographic locations mentioned above. Within each peer group, the resource use reports indicated whether the physician fell over the 90th percentile (high cost benchmark), below the 10th percentile (low cost benchmark), or over the 50th percentile (median cost benchmark). We solicited public comments on which cost benchmarks make the resource use reports meaningful, actionable, and fair (73 FR 69869).

Comment: Commenters supported the use of high, median, and low cost benchmarks because the benchmarks highlight useful cost categories within a given peer group.

Response: We agree with commenters that the high, median, and low cost benchmarks are appropriate. We intend to finalize these cost benchmarks as options to include in the Program in the CY 2010 PFS final rule with comment period.

Comment: A few commenters expressed support for including small geographic areas for benchmarking.

Response: Though we recognize that a small geographic benchmark may capture a more homogenous beneficiary population for comparison, smaller sample sizes may adversely affect the statistical precision of the comparison. A larger sample captured through broader geographic benchmarks makes

it less likely that physicians will be erroneously identified as high or low cost outliers.

In addition to commenting on specific statutory parameters, commenters also provided feedback on other general topics. Those comments and responses are included below.

Comment: A few commenters mentioned the use of proprietary commercial episode grouper software as a barrier to transparency within the Program. These commenters indicated that in order to understand and validate the resource use reports, physicians would need additional information about how the proprietary commercial software allocated costs to episodes.

Response: One of the primary goals of CMS' VBP initiatives is to implement performance-based incentive payment programs with transparent methodologies. We note that the Program is currently limited under section 1848(n)(1)(A) of the Act to confidential reporting. Use of physician resource use information for other purposes, such as payment or public reporting, would likely require a higher level of transparency than confidential reporting.

We note that we have previously discussed the use of proprietary products for payment purposes in previous rules published in the **Federal Register**. For example, we discussed the use of a proprietary product prior to implementation of the MS–DRGs in the FY 2007 IPPS final rule (72 FR 47171).

We recognize the efforts of episode grouper vendors toward improved transparency. For more information on episode groupers that is publicly available, we refer readers to the following Web sites: http://www.thomsonreuters.com/ and http://www.thomsonreuters.com/ business units/healthcare/.

We are soliciting public comment on the use of proprietary products to measure episodes of the care in the Program.

Comment: Some commenters expressed that the best method for dissemination of resource use reports is paper copies distributed via the mail. Others favored an electronic mechanism for dissemination. Some commenters expressed that resource use reports should be made available in both paper format and electronically.

Response: For phase I of the Program, we disseminated reports in paper form via mail. We agree with commenters that electronic dissemination would also be desirable. Pending resource availability, we will consider this

suggestion in a future phase of the Program.

d. Phase I of the Program

As indicated above, the Program consists of multiple phases. Under this approach, each phase of the Program will inform future phases of the Program. We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a description of phase I Program activities. Using the parameters that were finalized on an interim basis, we have disseminated approximately 230 resource use reports to physicians in each of the 12 geographic regions listed above in this section. We refer readers to the following Web site to review a deidentified sample of the resource use reports disseminated to physicians: http://rurinfo.mathematica-mpr.com/. We are soliciting public comment on the design and elements of the sample resource use report used in phase I of the Program. We are particularly interested in receiving comment on the usefulness of the cost of service category drill-down analysis included on pages 10, 16, 20, 24, 28, 32, and 36 of the sample resource use report. These comments will inform future phases of the Program.

e. Phase II of the Program

For phase II, we are proposing to expand the Program in ways that will make the information more meaningful and actionable for physicians. We are proposing to add reporting to groups of physicians recognizing that physicians practice in various arrangements. Group level reporting provides a mechanism for addressing sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant reports. We are also proposing to add quality measurement information as context for interpreting comparative resource use. These proposals are addressed in greater detail below in this section.

Phase I of the Program focused on providing confidential feedback on resource use measures to individual physicians. Section 1848(n)(1)(A) of the Act states that the Secretary may also provide confidential feedback reports to groups of physicians. Many physicians practice in groups. Recognizing groups of physicians within the Program is consistent with other CMS VBP initiatives and demonstrations under the Medicare program.

We are proposing to provide reports to groups of physicians, in addition to providing reports to individual physicians, for the Program. In

December 2008, CMS posted an Issues Paper on the Development of a Transition to a Medicare Physician Value-Based Purchasing Program for Physician and Other Professional Services.¹ The Issues paper describes cost of care measurement, the focus of Phase I of this Program, as one of the central tenets of Physician Value-Based Purchasing (see section II.G.4. of this proposed rule). Further, the Issues Paper referenced possible groups of physicians under consideration including: (1) Formally established single or multispecialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care. We are soliciting public comments on the appropriateness of resource use measurement and reporting for these and other groups of physicians.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A) of the Act states that the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician. Providing physicians with feedback on both quality and cost of care better captures the value of the care provided. Including quality measures in the Program is consistent with the direction for other CMS VBP initiatives.

We are proposing the use of quality measures, in addition to resource use measures, for the Program. Possible sources of quality measures include the Physician Quality Reporting Initiative (PORI) (see section II.G.2. of this proposed rule) and the Generating Medicare Physician Quality Performance Measurement Results (referred to as GEM) Project.² We refer readers to the Issues Paper, mentioned above,³ for additional discussion on how CMS would use quality measures in this Program and for Physician Value-Based Purchasing (see section II.G.4. of this proposed rule). We are soliciting public comments on the use of PQRI, GEM, and other broader aggregate quality measures to be used to capture value for the groups proposed above in the Physician Resource Use Measurement and Reporting Program.

¹ http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.

² http://www.cms.hhs.gov/GEM/.

³ http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.

4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

a. Background

Value-based purchasing uses payment incentives and transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the PFS. Section 131(d) of the MIPPA also states that by May 1, 2010, the Secretary shall submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The Secretary, through the Physician and Other Health Professional VBP (PVBP) Workgroup, submitted a progress letter to Congress on January 8, 2009 detailing the progress made on the VBP plan for physicians and other professionals.

Currently, Medicare health professional payments are based on quantity of services and procedures provided, without recognition of quality or efficiency. Under various authorities, we have pursued the implementation of building blocks to support the establishment of a VBP program for health professionals. These include initiatives in the following major topic areas: Quality and efficiency measurement and reporting, approaches for aligning incentives with providing higher quality care instead of higher volume of care, care coordination, prevention, and health information technology (HIT). The following is a list of examples of the initiatives specifically relevant to physicians and other health professionals:

- Pay for reporting of quality measurement data instituted under the Physician Quality Reporting Initiative (PORI):
- Resource use reports comparing overall costs, as well as costs for treatment across episodes of care, as part of, as required by the Physician Resource Use Feedback Program (See section II.G.3. of this proposed rule); and
- Demonstration projects, including the Physician Group Practice demonstration of a shared savings model, gainsharing demonstrations, medical home and other care coordination and disease management demonstrations, and the Acute Care

Episodes demonstration of a bundled payment model.

We are fully committed to implementing VBP incentives to drive quality improvement and greater efficiency for services furnished to Medicare beneficiaries.

b. Approach to Plan Development

We have created an internal crosscomponent team, the PVBP Workgroup, to lead development of the PVBP Plan. Four Subgroups were established to address the major sections of the Plan: Measures; incentives; data strategy and infrastructure; and public reporting. The PVBP Workgroup was tasked with reviewing the state-of-the-art in performance-based payment for physicians, including relevant Medicare programs and demonstrations and private sector initiatives; preparing an Issues Paper to present program objectives and design principles; engaging stakeholders and obtaining input on program design; and developing the PVBP Plan and Report to Congress. A similar approach was used in the development of the CMS Hospital

To guide the planning process, the PVBP Workgroup adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the Workgroup has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency.
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care.
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care.
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.
- Empower consumers to make valuebased health care choices and encourage health professionals to improve the value of care by disseminating actionable performance information.

The goal and objectives were captured in an Issues Paper that was posted on the CMS Web site on November 24, 2008, in preparation for the December 9, 2008 Listening Session which was held at CMS headquarters. The Issues Paper included questions seeking public input on key design considerations. The Issues Paper is available on the CMS Web site at http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf. Nearly 500 stakeholders participated in the day-long Listening Session. We received both verbal and written comments that are informing the design of the PVBP Plan.

c. Stakeholder Input From the Listening Session

Both at the Listening Session, and in written comments received following the Session, we obtained input from a wide range of diverse stakeholders. A large portion of the comments were received from physician and other professional specialty societies. Commenters also included consumer advocates, health care consulting firms, and health IT vendors, and individual practicing physicians.

(1) Overarching Issues

Commenters generally affirmed the goal and objectives presented in the Issues Paper. Commenters encouraged the consideration of new payment approaches that cut across settings of care to align Medicare Part A and Part B payment incentives. Many commenters stated that the current Medicare payment system for health professionals is flawed in that it fails to align incentives for high-value care across providers and settings and that this cannot be fixed solely by a VBP program. Commenters agreed with the Issues Paper assumption that the Plan will need to contain more than one approach to accommodate different practice arrangements. Several commenters praised the attention given in the Issues Paper to addressing disparities and pointed out the necessity of adequate risk adjustment and proper use of measures, incentives, and program evaluation to protect vulnerable populations. Commenters also urged careful attention to the operational transition from the current payment system to VBP to minimize care delivery disruptions.

(2) Measurement

Commenters emphasized the importance of aligning measures across payment settings and applying measures consistently across payers. Many commenters stressed the need for valid, reliable, nationally-recognized measures, particularly in the areas of outcomes, care coordination, patient

experience, and the effective use of HIT. Adequate risk adjustment was raised as a paramount issue for outcomes and resource use measures. Regarding resource use measures, several commenters noted that quality and cost measures should be reported together and that CMS should get experience with confidential feedback reporting of resource use before using the information for incentives or public reporting (See section II.G.3. of this proposed rule). A few commenters suggested avoidable readmission rates as a good measure of both cost and quality of care. Commenters emphasized the importance of CMS working with health professionals on the selection of quality and cost measures.

Commenters generally agreed with the Issues Paper assumption that the Plan should address multiple levels of accountability, including individual health professionals, care teams, group practices, and accountable care entities. A few commenters mentioned that performance measurement at the regional level could help address regional variation. Consumer advocates made strong arguments for individual accountability, while noting that care delivery is ultimately a team effort. Others noted that measurement is more difficult at the individual level and that accountability at more aggregated levels could support promising payment models like bundled payment, gainsharing, and shared savings.

(3) Incentives

Commenters noted that incentive payments should be large enough to be meaningful, be made timely, and at least cover the cost of participating in the program. Commenters encouraged us to coordinate the incentives, as well as measures, with other payers. Many commenters stated that incentives should reward both improvement and attainment, and not be based on a ranking system that rewards only high attainers; instead, all who perform above a certain prospective benchmark should earn the incentive. Several commenters indicated that use of incentives could be an effective way to promote the use of effective HIT. Most commenters agreed that more than one incentive structure would be necessary to address different practice arrangements and to focus effort on specific objectives (for example, care coordination).

(4) Data Strategy and Infrastructure

Commenters emphasized that the administrative burden of data exchange, for both health professionals and CMS, should be minimized. Several commenters noted that clinical data registries and direct reporting from electronic health records were superior approaches to claims-based reporting for gathering clinical data. Commenters indicated that feedback on performance should be timely and detailed enough to be actionable. Commenters also asked for the opportunity to review and appeal the accuracy of their performance assessments prior to use of that information for payment incentives or public reporting.

(5) Public Reporting

Consumer advocates highlighted the importance of transparency while professional associations urged caution to assure that publicly reported information not be inaccurate or misleading for consumers. Several commenters noted that public reporting should address multiple levels of accountability, including individual health professionals, the care delivery team, group practices, and at the regional level. All agreed that publicly reported information should be user-friendly.

d. Next Steps in Plan Development

Building on input from the Listening Session on the Issues Paper topics, the PVBP Workgroup has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

(1) Overlay the current PFS, such as differential fee schedule payments based on measured performance or for providing a medical home;

(2) Address multiple levels of accountability, including individual health professionals, as well as larger teams or organizations; and

(3) Promote more integrated care through shared savings models and bundled payment arrangements.

We are seeking further public comment on the development of the PVBP plan and Report to Congress. Comments already submitted by participating in person at the December 9, 2008 Listening Session or as written comments following the Session, do not need to be resubmitted. At this time, we are soliciting original comments that were not previously submitted. Particularly, we are interested in the

comments further discussing the issues of the appropriate level of accountability (for example, group practice, individual, region), and appropriate data submission mechanisms. The PVBP Workgroup will use public comment to inform its development of the Plan and Report to Congress.

- 5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program
- a. Program Background and Statutory Authority

As defined in § 423.159(a), e-prescribing is the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

As discussed in the CY 2009 PFS final rule with comment period (73 FR 69847), there are many potential advantages to e-prescribing. Yet, there has been limited adoption and use of electronic prescribing by physicians and other professionals who prescribe medications. It is estimated that only 12 percent of office-based prescribers currently use e-prescribing (Surescripts. "National Progress Report on E-Prescribing." Welcome to the E-Prescribing Resource Center. 2008. Surescripts. 15 May 2009. http:// www.surescripts.com/downloads/NPR/ national-progress-report.pdf).

As described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69848), the MMA and the creation of the Medicare Prescription Drug Benefit Program (Part D) promoted the use of e-prescribing by requiring the adoption of uniform standards for the Medicare Part D electronic prescribing ("e-prescribing") program. As required by section 1860D-4(e) of the Act, "foundation standards" were adopted on November 7, 2005 (70 FR 67568) and additional Part D e-prescribing standards were adopted on April 7, 2008, and were implemented April 1, 2009 (73 FR 18918). Section 1848(m) of the Act, as amended by section 132 of the MIPPA, further promotes the use of e-prescribing by authorizing incentive payments to eligible professionals or group practices who are "successful electronic prescribers." This E-Prescribing Incentive Program is expected to encourage significant expansion of the use of e-prescribing by

authorizing a combination of financial incentives and payment adjustment and is separate from, and in addition to, any incentive payment that eligible professionals may earn through the PQRI program discussed in section II.G.2. of this proposed rule. Eligible professionals do not have to participate in PQRI to participate in the E-Prescribing Incentive Program (and vice versa).

For 2010, which is the second year of the E-Prescribing Incentive Program, the Secretary is authorized to provide successful e-prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 2.0 percent of the total estimated (based on claims submitted not later than 2 months after the end of the reporting period) allowed charges for all covered professional services furnished during the 2010 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional. The applicable electronic prescribing percent (2 percent) authorized for the 2010 E-Prescribing Incentive Program is the same as that authorized for the 2009 E-Prescribing Incentive Program.

Subject to section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of the HITECH Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act) (Pub. L. 111–5), which was enacted on February 17, 2009, the incentive payments for successful electronic prescribers for future years are authorized under section 1848(b)(2)(C) of the Act as follows:

- 1.0 percent for 2011.
- 1.0 percent for 2012.
- 0.5 percent for 2013.

Section 1848(m)(2)(D) of the Act, as added by section 4001(f)(2)(B) of the Recovery Act, specifies a limitation to the e-prescribing incentive in relation to whether the EHR incentive authorized by the Recovery Act is earned. Section 1848(m)(2)(D) of the Act specifically provides that the e-prescribing incentive does not apply to an eligible professional (or group practice), if, for the EHR reporting period, the eligible professional (or group practice) earns an incentive payment under the new Health Information Technology (HIT) incentive program authorized by the Recovery Act for eligible professionals who are meaningful EHR users. The new HIT incentive program for meaningful EHR users begins in 2011. Therefore, beginning in 2011, eligible professionals who earn an incentive

under the new HIT incentive program for meaningful EHR users, with respect to a certified EHR technology that has eprescribing capabilities, would not be eligible to earn a separate incentive payment for being a successful electronic prescriber under the Eprescribing Incentive Program.

In addition, under section 1848(a)(5)(A) of the Act, as added by section 132(b) of the MIPPA and amended by section 4001(f)(1) of the Recovery Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee schedule amount that would otherwise apply by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We note that the criteria for determination of successful electronic prescriber proposed herein may not necessarily be the criteria that will be used to determine the applicability of the payment adjustment in the future. Policy considerations underlying the application of the incentive payment are not necessarily the same as those in applying a payment adjustment. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of e-prescribing, even for low volume prescribers. On the other hand, a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an eprescribing system may be impractical given the low volume of prescribing. We will discuss the application of the payment adjustment in future notice and comment rulemaking, but prior to the beginning of the reporting period that will be used to determine the applicability of the payment adjustment. Under section 1848(m)(6)(A) of the

Under section 1848(m)(6)(A) of the Act, the definition of "eligible professional" for purposes of eligibility for the E-Prescribing Incentive Program is identical to the definition of "eligible professional" for the PQRI under section 1848(k)(3)(B) of the Act. In other words, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, for purposes of the E-

prescribing Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the E-Prescribing Incentive Program is available on the "Eligible Professionals" page of the E-Prescribing Incentive Program section of the CMS Web site at http://www.cms.hhs.gov/ERXIncentive.

Similar to the PQRI, the E-Prescribing Incentive Program, in 2009, is an incentive program in which determination of whether an eligible professional is a successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an eligible professional is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination. Then, payment will be made to the applicable holder of the TIN. For 2010, the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act requires the Secretary by January 1, 2010 to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice are successful electronic prescribers, we will also begin making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber.

b. The Proposed 2010 Reporting Period for the E-Prescribing Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" for the 2010

E-Prescribing Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, as added by the MIPPA, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We propose the 2010 E-Prescribing Incentive Program reporting period will be the entire year (January 1, 2010-December 31, 2010). We believe that keeping the 2010 E-Prescribing Incentive Program reporting period consistent with the 2009 E-Prescribing Incentive Program reporting period will help to maintain program stability and be less confusing for eligible professionals.

Successful electronic prescribers would be eligible to receive an incentive payment equal to 2.0 percent of the total estimated allowed charges (based on claims submitted by no later than February 28, 2011) for all covered professional services furnished January 1, 2010 through December 31, 2010.

c. Proposed Criteria for Determination of Successful E-Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a "successful electronic prescriber," which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any e-prescribing quality measures that have been established under the physician reporting system under subsection 1848(k) (which, as noted previously, we have named "PORI" for ease of reference) and are applicable to services furnished by the eligible professional during a reporting period. The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a "sufficient" number of prescriptions has been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number

(as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on e-prescribing measures would no longer apply.

For 2009, as described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69852), we required eligible professionals to report on the eprescribing measure that had been previously used in the 2008 PQRI. For 2010, we propose to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 E-Prescribing Incentive Program to determine whether an eligible professional is a successful eprescriber, but we propose to use

modified reporting criteria.

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69848), we intend to consider the use of a certain number of Part D prescribing events as the basis for the incentive payment in future years. However, we do not believe that it is feasible to move to this substitute requirement in 2010. The accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown. Information on whether a prescription was submitted electronically by an individual eligible professional will not be collected on the Part D claims, or prescription drug event (PDE) data, until 2010. Also, prescription drug plan sponsors were not required to send PDE data with an individual prescriber's NPI until April 1, 2009. We currently have no information on the accuracy and completeness of the NPI data that is submitted with the PDE data. The NPI is needed in order for us to be able to link an eligible professional's PDE data to his or her Medicare Part B claims to calculate the incentive payment amount. During 2010, we expect to evaluate the adequacy of Part D data to determine the feasibility of its use for determining whether an eligible professional qualifies as a successful eprescriber in future years.

(1) Reporting the Electronic Prescribing Measure

For 2009, we limited the reporting mechanism for the electronic prescribing measure to claims-based reporting. For 2010, we propose 3 reporting mechanisms for individual eligible professionals. First, we propose to retain the claims-based reporting mechanism that is used in the 2009 E-Prescribing Incentive Program. In addition, similar to the PQRI, for the Eprescribing Incentive Program, we propose to implement a registry-based

reporting mechanism and, depending on whether we finalize the proposed EHRbased reporting mechanism for PQRI, we are also proposing that an EHR based reporting mechanism be available for the electronic prescribing measure. In other words, eligible professionals would be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product. As we stated in our discussion of the proposed PQRI reporting mechanisms for 2010 in section II.G.2.d. of this proposed rule, we recognize that one mode of quality reporting does not suit all practices. Similar to the PQRI, we believe that having multiple reporting mechanisms for the reporting of the electronic prescribing measure should increase opportunities for eligible professionals to successfully report the electronic prescribing measure. We invite comments on our proposal to provide alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure.

We propose that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. We note that not all registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit quality measure results and numerator and denominator data on the e-prescribing measure. PQRI qualified registries will be qualified to submit specific types of measures. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries who self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit. Registries will need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their selfnomination letter for the 2010 PQRI. The self-nomination process and

requirements for registries for the PQRI, which also would apply to the registries for the 2010 E-Prescribing Incentive Program, are discussed in section II.G.2.d.(4) of this proposed rule. We will post a list of qualified registries for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at http://www.cms.hhs.gov/ERXIncentive when we post the list of qualified registries for the 2010 PQRI on the PQRI section of the CMS Web site.

Similarly, we propose that only EHR products "qualified" to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI would be considered "qualified" for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. The selfnomination process and requirements for EHR vendors for the PQRI, which also would apply to the EHR vendors for the 2010 E-Prescribing Incentive Program are discussed in section II.G.2.d.(5) of this proposed rule. EHR vendors will need to indicate their desire to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their selfnomination letter for the 2010 PQRI. If we finalize the EHR-based reporting mechanism for the 2010 PQRI, we will post a list of qualified EHR vendors and their products (including the version that is qualified) for the 2010 E-Prescribing Incentive Program, on the E-Prescribing Incentive Program section of the CMS Web site at http:// www.cms.hhs.gov/ERXIncentive when we post the list of qualified EHR products for the 2010 PQRI on the PQRI section of the CMS Web site. We welcome comments on our proposal to limit the registries and EHR products qualified to submit the electronic prescribing measure for the 2010 E-Prescribing Incentive Program to those that are qualified registries and EHR products, respectively, for the 2010 PQRI.

(2) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the PQRI measures, has 2 basic elements. These include: (1) A reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional as Part B covered professional services. For 2009, the codes included in the measure's denominator were codes that are typically billed for services in the office or outpatient setting furnished by physicians or other eligible professionals. There are no diagnosis codes or age/gender requirements in order to be included in the measure's denominator (that is, reporting of the eprescribing measure is not further limited to certain ages or a specific gender). However, as discussed further under section II.G.5.c.(5) of this proposed rule, eligible professionals are not required to report this measure in all cases in which the measure is reportable. Physicians and other eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

Currently, the denominator codes for the electronic prescribing measure consist of the following CPT and G-codes: 90801; 90802; 90804; 90805; 90806; 90807; 90808; 90809; 92002; 92004; 92012; 92014; 96150; 96151; 96152; 99201; 99202; 99203; 99204; 99205; 99211; 99212; 99213; 99214; 99215; 99241; 99242; 99243; 99244; 99245; G0101: G0108: G0109.

As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, however, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we propose, in response to public comments received, to expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. We propose to add the following CPT codes to the denominator of the electronic prescribing measure for 2010: 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; 99350; and 90862. The proposed expansion of the electronic prescribing measure denominator is expected to provide more eligible professionals the opportunity to report the measure, and thus, provide more opportunities for eligible professionals to participate in the E-Prescribing Incentive Program. We

invite comments on the proposed changes to codes identified for the electronic prescribing measure denominator.

By December 31, 2009, we will post the final specifications of the measure on the "E-Prescribing Measure" page of the E-Prescribing Incentive Program section of the CMS Web site at http://www.cms.hhs.gov/ERXIncentive.

(3) Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report the electronic prescribing measure in 2010, we propose that the eligible professional must report 1 of 3 "G" codes, as will be discussed below. However, in reporting any of the Gcodes and thereby qualifying for the incentive payment for e-prescribing in 2010, the professional must have and regularly use a "qualified" electronic prescribing system as defined in the electronic prescribing measure specifications. If the professional does not have general access to an eprescribing system in the practice setting, there is nothing to report. Required Functionalities for a "Qualified" Electronic Prescriber System. What constitutes a "qualified" electronic prescribing system is based upon certain required functionalities that the system can perform. As currently specified in the measure, a "qualified" electronic prescribing system is one that can:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2010 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D E-Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act, to the extent practicable, in determining whether an eligible professional is a successful e-prescriber, "the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D-4(e)" of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the Eprescribing Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D eprescribing program. Additional Part D e-prescribing standards were implemented April 1, 2009. These latest Part D e-prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at http://www.cms.hhs.gov/eprescribing.

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a "qualified" electronic prescribing system must utilize the adopted Part D e-prescribing standards. The Part D eprescribing standards relevant to the four functionalities for a "qualified" system in the electronic prescribing measure, described above and listed as

(a), (b), (c), and (d), are:

(a) Generate medication list—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/ Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1. October 2005 (hereinafter "NCPDP SCRIPT 8.1") Medication History Standard;

(b) Transmit prescriptions electronically—Use the NCPDP SCRIPT 8.1 for the transactions listed at

§ 423.160(b)(2);

(c) Provide information on lower cost alternatives—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter "NCPDP Formulary and Benefits 1.0");

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan—use:

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans.

(2) Accredited Standards Committee (ASC) X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibly information between the plan and prescribers.

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

There are, however, Part D eprescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a "qualified" system under the electronic prescribing measure. One example is Rx Fill Notification, which is discussed in the Part D e-prescribing final rule (73 FR 18918, 18926). For purposes of the 2010 Electronic Prescribing Program and incentive payments, it is not required that the electronic prescribing system contain all functionalities for which there are available Part D e-prescribing standards. Rather, the only required functionalities are those stated in the measure and described above in the section entitled "Required Functionalities for a 'Qualified' Electronic Prescribing System." For those required functionalities described above, we propose that a "qualified" system must use the adopted Part D e-prescribing standards for electronic messaging.

There are other aspects of the functionalities for a "qualified" system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The

electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a "qualified" system having the functionalities described above based on Part D e-prescribing standards.

(4) The Reporting Numerator for the **Electronic Prescribing Measure**

Currently, to report for an applicable case where 1 of the denominator codes is billed for Part B services, an eligible professional must report one of 3 Gcodes specified in the electronic prescribing measure. Currently, the Gcodes are the following:

- One G-code is used to report that all prescriptions in connection with the visit billed were electronically prescribed (G8443);
- · Another G-code indicates that no prescriptions were generated during the visit (G8445); and
- A third G-code is used when some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance (G8446).

However, for 2010, we propose to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed. In addition, we propose to eliminate the 2 remaining G-codes from the measure's numerator: G8445; and G8446. We believe these modifications to the electronic prescribing measure will simplify reporting of the measure because the measure will only be reportable when an eligible professional has electronically prescribed. We invite comments on the proposed modifications to the electronic prescribing measure numerator.

The e-prescribing quality measure would not apply unless an eligible professional furnishes services indicated by one of the codes included in the measure's denominator. Therefore, for claims-based reporting, for example, it is not necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Part B claim containing one of the eprescribing quality measure's denominator codes.

(5) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed above, section 1848(m)(3)(B)(ii) of the Act specifies that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases. However, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(3)(B)(ii) of the Act for years after 2009. Therefore, we propose to revise the criteria for submitting data on the electronic prescribing measure. For 2010, rather than requiring that the electronic prescribing measure be reported for a certain proportion of reportable cases, we propose to make the determination of whether an eligible professional is a successful electronic prescriber based on a count of the number of times an eligible professional reports that at least one prescription created during the encounter was generated using a qualified e-prescribing system (that is, reports the modified G8443 code). We believe that modifying the criteria for submitting the electronic prescribing measure in this manner will bring us closer to our stated intention to transition to using a certain number of electronic Part D prescribing events as the basis for the incentive payment in future years. In proposing to revise the criteria for successful reporting of the electronic prescribing measure in this manner, we also assume that once an eligible professional has invested in an e-prescribing system, integrated the use of the e-prescribing system into the practice's work flows, and has used the system to some extent, he or she is likely to continue to use the eprescribing system for most of the prescriptions he or she generates.

Preliminary data from the 2008 PQRI through September 2008 indicate that half of the eligible professionals who were eligible to report the electronic prescribing measure under the 2008 PQRI (measure #125) had 132 or more instances in which they were eligible to report the measure, with a maximum of 12,655 reporting instances. Therefore, in order to successfully report the measure under the 2009 criteria for successful eprescribing (that is, reporting the measure for at least 50 percent of applicable cases), half of eligible professionals would have had to report measure #125 66 times or more (that is, 50 percent of 132 reporting instances),

with a maximum of 6,328 times (that is, 50 percent of 12,655 reporting instances). For structural measures such as the electronic prescribing measure, once an eligible professional has demonstrated that he or she has integrated use of an e-prescribing system into his or her practice's work flow, requiring the eligible professional to continue to report the measure represents an administrative burden with little added benefit to the reliability and validity of the data being reported. In contrast, for clinical quality measures, the reliability and validity of the performance rates depends on the adequacy of the sample. Therefore, we propose that an eligible professional would be required to report that at least 1 prescription for a Medicare Part B FFS patient created during an encounter that is represented by 1 of the codes in the denominator of the electronic prescribing measure was generated using a qualified e-prescribing system for at least 25 times during the 2010 reporting period.

The proposed minimum reporting threshold of 25 is based on the notion that an eligible professional would need to e-prescribe, on average, for approximately 2 Medicare Part B FFS patient encounters per month during the reporting period in order to be considered a successful e-prescriber. The proposed reporting threshold of 25 also takes into consideration that prescriptions are not generated with every Medicare Part B FFS patient encounter and some prescriptions, such as narcotics, cannot be prescribed electronically.

We welcome comments on the proposed criteria for determination of successful electronic prescriber. We are particularly interested in comments related to the following:

- Our proposal to change the criteria for determining whether an eligible professional is a successful e-prescriber from requiring reporting of the electronic prescribing measure in 50 percent of applicable cases to a count of the number of times the eligible professional electronically prescribed; and
- The proposed threshold number of 25 times in which an eligible professional would be required to report that he or she electronically prescribed during the reporting period.
- d. Determination of the 2010 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful E-Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the E-prescribing incentive payment. The

Secretary is authorized to choose 1 of 2 possible criteria for the limitation. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Part B allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the eligible professional submits (both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies to the future application of the payment adjustment.

As discussed above, for 2010, we propose to make the determination of whether an eligible professional is a "successful e-prescriber" based on submission of the electronic prescribing measure. As a result, we propose to apply the criterion under section 1848(m)(2)(B)(i) for the limitation for the 2010 E-Prescribing Incentive Program. Therefore, in determining whether an eligible professional will receive an e-prescribing incentive payment for 2010, we would determine whether the 10 percent threshold is met based on the claims submitted by the eligible professional at the TIN/NPI level. This calculation is expected to take place in the first quarter of 2011 and would be performed by dividing the individual's total 2010 allowed charges for all such covered professional services submitted for the measure's HCPCS codes by the individual's total allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful e-prescriber would earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional would not earn an e-prescribing incentive payment—even if he or she electronically prescribes and reports G8443 at least 25 times for those eligible cases that occur during the 2010 reporting period. Although an individual eligible professional may

decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

e. Proposed Reporting Option for Satisfactory Reporting of the E-Prescribing Measure by Group Practices

As discussed previously, section 1848(m)(3)(C)(i) requires that by January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under subsection (a)(5), for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary.

Section 1848(m)(3)(C)(ii) of the Act requires that the process established under section 1848(m)(3)(C)(i) of the Act provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A of the Act. In addition, section 1848(m)(3)(C)(iii) of the Act specifies that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(ii) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for being a successful e-prescriber. Therefore, while we will be making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful e-prescriber for 2010, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that successfully meets the proposed requirements for group practices would not be eligible to earn a separate e-prescribing incentive payment for 2010 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

(1) Definition of "Group Practice"

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define "group practice." For purposes of determining whether a group practice is a successful eprescriber, we propose that a "group practice" would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, NPIs) who have reassigned their billing rights to the TIN to be consistent with definition of "group practice" proposed for the PQRI group practice reporting option.

However, we propose to limit the group practices eligible to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option to those group practices selected to participate in the PORI group practice reporting option. At this time, we would like to limit the number of groups participating in the group practice reporting option until we get further experience with the group practice reporting option. Therefore, unlike individual eligible professionals who are not required to participate in the PQRI to be eligible to earn an eprescribing incentive and vice versa, group practices would be required to participate in both PQRI and the E-Prescribing Incentive Program. As discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PORI section of the CMS Web site by November 15, 2009. In addition to meeting the eligibility requirements proposed in section II.G.2.g.(1) of this proposed rule, a group practice would also have to indicate how they intend to report the electronic prescribing measure (that is, which proposed reporting mechanism the group practice intends to use) for purposes of participating in the 2010 E-Prescribing Incentive Program group practice reporting option.

(2) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the E-Prescribing Measure by Group Practices

For group practices selected to participate in the e-prescribing group practice reporting option for 2010, we propose the reporting period would be January 1, 2010 to December 31, 2010.

We propose that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, contingent upon us finalizing this reporting mechanism for the 2010 PQRI, the EHR-based reporting mechanism. As we proposed for individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI would be qualified for purposes of the 2010 e-prescribing group practice reporting option.

In order for a group practice to be considered a successful e-prescriber, we propose the group practice would have to report that at least 1 prescription during an encounter was generated using a qualified e-prescribing system in at least 2,500 instances during the

reporting period.

In the absence of information about the composition of the group practices that may wish to participate in the E-Prescribing Incentive Program through the group practice reporting option rather than as individual eligible professionals, we assumed that the average group practice consists of 200 eligible professionals and that as many as half of the members of an average group practice do not furnish the services represented by the electronic prescribing measure's denominator codes, and thus, would not have an opportunity to report the electronic prescribing measure. Second, to be consistent with the proposed reporting criteria for individual eligible professionals, we also believe that each eligible professional in a group practice should be required to report that at least 1 prescription generated during an encounter that is represented by 1 of the electronic prescribing measure's denominator codes was generated electronically at least 25 times. Thus, for a group of 200 eligible professionals, we could extrapolate from our assumption that only half of the eligible professionals in an average practice of 200 eligible professionals would have the opportunity to report the electronic prescribing measure per group practice, the total number of reporting instances for the 100 remaining eligible professionals would be 2,500. We invite comments on the proposed criteria for determining whether a group practice is a successful e-prescriber. We also invite feedback on our underlying assumptions.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the e-prescribing incentive discussed in section II.G.5.d.

of this proposed rule applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an e-prescribing incentive payment for 2010 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice. This calculation is expected to take place in the first quarter of 2011 and would be determined by dividing the group practice's total 2010 allowed charges for all covered professional services submitted for the measure's HCPCS codes by the group practice's total Medicare Part B allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation will not apply and a group practice that is determined to be a successful e-prescriber would qualify to earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the group practice would not qualify to earn the e-prescribing incentive payment.

f. Public Reporting of Names of Successful E-Prescribers

As discussed in section II.G.2.k. of this proposed rule, section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful eprescribers. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule with comment period (73 FR 69851 through 69852) our intent, in 2010, to post the names of eligible professionals who are successful e-prescribers for the 2009 E-Prescribing Incentive Program at http:// www.medicare.gov.

As required by section 1848(m)(5)(G) of the Act, we propose to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory. The names of individual eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of individual eligible professionals on the Physician and

Other Health Care Professionals Directory, we propose to post the names of individual eligible professionals: (1) Whose 2010 PFS allowed charges make up at least 10 percent of the eligible professional's Medicare Part B charges for 2010; (2) who report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 25 times during the 2010 reporting period; and (3) who receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI and a successful electronic prescriber if he or she meets the criteria for both incentive programs.

For purposes of publicly reporting the names of group practices on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 2500 times during the 2010 reporting period; and (2) receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Although group practices would be required to participate in both programs to earn an incentive under either program, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber or vice versa.

6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act to a supplier who is accredited by an accreditation organization designated by the Secretary.

a. Accreditation Requirement

This proposed rule would set forth the criteria for designating organizations to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging services as specified in section 1834(c) of the Act. In addition, it would set forth the required procedures to ensure that the criteria used by an accreditation organization meet minimum standards for each imaging modality. These statutory requirements would be codified in § 414.68 of the payment rules for physicians and other practitioners.

The CMS-designated accreditation organization would apply standards that set qualifications for medical personnel who are not physicians but who furnish the TC. The standards would describe the qualifications and responsibilities of medical directors and supervising physicians including the following: Recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician; has completed any continuing medical education courses related to advanced imaging services; or has met such other standards as the Secretary determines appropriate. In addition, the standards would require suppliers to: (1) Establish and maintain a quality control program to ensure the technical quality of diagnostic images produced by the supplier; (2) ensure the equipment used meets performance specifications; and (3) ensure safety of personnel. While the statute authorizes the Secretary to establish as criteria for accreditation any other standards or procedures the Secretary determines appropriate, we are not proposing to establish other standards or procedures

We expect to publish a notice to solicit applications from entities for the purposes of becoming a designated accreditation organization the same day that this proposed rule's subsequent final rule is issued, on or before November 1, 2009. Due to the tight timeframe, we expect to meet the January 1, 2010 statutory deadline in

order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by waiving the 60-day delay in the imaging accreditation provisions of the final rule.

b. Accreditation for Suppliers

Section 1834(e) of the Act requires the Secretary to designate and approve accreditation organizations to accredit suppliers of the TC of advanced diagnostic imaging services. To promote consistency in accrediting providers and suppliers throughout the Medicare program, we are proposing to use existing procedures for the application, selection, and oversight of accreditation organizations detailed at 42 CFR part 488, subparts A and D and apply them to organizations accrediting suppliers of the TC of advanced diagnostic imaging services. We are proposing modifications to the existing part 488 requirements to meet the specialized needs of the advanced imaging industry. These modifications will require an independent accreditation organization applying for approval as a designated accreditation organization to include in their application:

- A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically:
- + Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services:
- Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;
- + Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished:
- + Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.
- An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.
- Information to demonstrate the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.
- The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation and any plans for reducing

the burden and cost of accreditation to small and rural suppliers.

• Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

If, after review of an accreditation organization's submission of information, we determine that additional information is necessary to make a determination for approval or denial of the accreditation organization's application to be designated as an accreditation organization for suppliers of the TC of advanced diagnostic imaging services, the organization will be notified and afforded an opportunity to provide the additional information. We may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff. The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied, the notice will include the basis for denial and outline the reconsideration procedures. We will make every effort to issue a final decision no more than 30 calendar days from the time the completed reapplication is received by CMS. An accreditation organization may withdraw its application for designation under section 1834(e) of the Act at any time before the formal notice of approval is received. An accreditation organization that has been notified that its request for designation has been denied may request reconsideration in accordance with § 488.201 through § 488.211 in Subpart D. Any accreditation organization whose request for designation has been denied may resubmit its application if the organization (1) revises its accreditation program to address the rationale for denial of its previous request; (2) provides reasonable assurance that its accredited companies meet applicable Medicare requirements; and (3) resubmits the application in its entirety. If an accreditation organization has requested a reconsideration of our determination that its request for designation under section 1834(e) of the Act is denied, it may not submit a new application for the type of modality that is at issue in the reconsideration until the reconsideration is final.

A panel will evaluate all proposals from accreditation organizations seeking designation under section 1834(e) of the Act using existing CMS survey and certification processes as established in § 488.4.

c. Payment Rules for Suppliers of the TC of Advanced Diagnostic Imaging Services (§ 414.68)

We would specify in § 414.68 the statutory requirement of section 1834(e) of the Act that all suppliers of the TC of advanced diagnostic imaging services be accredited by a CMS-designated accreditation organization by January 1, 2012 for payments made under the fee schedule established under section 1848(b). In § 414.68(a), we are proposing to define the following:

• "Accredited supplier" as a supplier that has been accredited by a CMS-approved accreditation organization.

- "Advanced Diagnostic Imaging Services" as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. We are not proposing at this time to include other diagnostic imaging services in this definition under section 1834(e)(1)(B)(ii) of the Act.
- "CMS-approved accreditation organization" as an independent accreditation organization designated by CMS to perform the accreditation function established in section 1834(e) of the Act.
- d. Ongoing Responsibilities of CMS-Approved Accreditation Organizations

We are proposing to require a CMSapproved accreditation organization to perform the following activities on an ongoing basis. Provide to CMS in written form and on an ongoing basis all of the following:

- Copies of all accreditation surveys of specific suppliers along with any survey-related information that we may require (including corrective action plans and summaries of CMS requirements that were not met).
- Notice of all accreditation decisions.
- Notice of all complaints related to suppliers of the TC of advanced diagnostic imaging service.
- Information about any suppliers of the TC of advanced diagnostic imaging service for which the accrediting organization has denied the supplier's accreditation status.
- Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implemented the changes before or without CMS approval, we could withdraw approval of the accreditation organization.
- Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.
- Provide CMS with written notice of any deficiencies and adverse actions

implemented by the CMS-approved accreditation organization against an accredited supplier of the TC of advanced diagnostic imaging within 2 days of identifying such deficiencies, if the deficiencies pose immediate jeopardy to a beneficiary or to the general public.

- Provide written notice of the withdrawal to all accredited suppliers within 10 days of CMS' notice to withdraw approval of the accreditation organization.
- Provide, on an annual basis, summary data specified by CMS that are related to the past year's accreditation activities and trends.
- e. Continuing CMS Oversight of CMS-Approved Accreditation Organizations

We are proposing to add § 414.68 to establish specific criteria and procedures for continuing oversight and for withdrawing approval of an approved accreditation organization.

(1) Validation Audits

We are proposing to audit the accredited organizations in order to validate the survey accreditation process of approved accreditation organizations in the TC of advanced imaging. The audits would be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we will specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. We are proposing to require a supplier selected for a validation audit to authorize the validation audit to occur and authorize the CMS team or our contractor to monitor the correction of any deficiencies found through the validation audit. If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would no longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of the advanced medical imaging would be revoked.

We are proposing that a CMS team or our contractor would conduct an audit of an accredited organization, examine the results of the accreditation organization's own survey procedure onsite, or observe the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we would identify any accreditation programs for which validation audit results indicated the following:

- A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that did not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that constituted immediate jeopardy to patient health and safety if not met; or
- There were widespread or systemic problems in the organization's accreditation process such that the accreditation no longer provided assurance that suppliers met or exceeded the Medicare requirements, irrespective of the rate of disparity.
- (2) Notice of Intent To Withdraw Approval for Designating Authority

If a validation audit, onsite observation, or our concerns with the ethical conduct (that impacts the health and safety of the beneficiary) of an accreditation organization suggest that the accreditation organization is not meeting the requirements of proposed § 414.68, we would provide the organization written notice of its intent to withdraw approval of the accreditation organization's designating authority.

(3) Withdrawal of Approval for Designating Authority

We are proposing to withdraw approval of an accreditation organization at any time if we determine that:

- Accreditation by the organization no longer provides sufficient assurance that the suppliers of the TC of advanced imaging meet the requirements of section 1834(e) of the Act and the failure to meet those requirements could pose an immediate jeopardy to the health and safety of Medicare beneficiaries;
- Constitutes a significant hazard to the public health; or
- The accreditation organization failed to meet its obligations for application and reapplication procedures.

(4) Reconsideration

We are proposing to implement requirements under part 488 without substantive changes as the requirements have been utilized for the health care providers covered under part 488 since

1992. We are proposing that an accreditation organization dissatisfied with a determination that its accreditation requirements did not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization met the applicable standards would be entitled to a reconsideration. We are also proposing to reconsider any determination to deny, remove, or not renew the approval of the designating authority to accreditation organizations if the accreditation organization filed a written request for reconsideration through its authorized officials or through its legal representative.

We are proposing to require the accreditation organization to file the request within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal. We propose to require the request for reconsideration to specify the findings or issues with which the accreditation organization disagreed and the reasons for the disagreement. A requestor could withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we would provide the accrediting organization the opportunity for an informal hearing that would be conducted by a hearing officer appointed by the CMS Administrator and provide the accrediting organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew its designating authority.

We would provide written notice of the time and place of the informal hearing at least 10 business days before the scheduled date. The informal reconsideration hearing would be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing would be conducted by the hearing officer who would receive testimony and documents related to the proposed action. Testimony and other evidence could be accepted by the hearing officer. However, it would be inadmissible under the usual rules of court procedures. The hearing officer would not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer would

present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer would include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision would be final.

We are interested in obtaining additional information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by State, and related information. It would be particularly helpful for the commenter to identify specific clinical scenarios with associated CPT codes that would represent such services involving RAs and RPAs.

7. Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of the MIPPA establishes a "special payment rule for teaching anesthesiologists" and provides a directive to the Secretary regarding payments for the services of "teaching certified registered nurse anesthetists" (teaching CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount (the regular fee schedule rate). These provisions are effective for services furnished on or after January 1, 2010.

a. Teaching Anesthesiologists: Special Payment Rule

The criteria for the payment of teaching anesthesiology services and the special rule for the teaching anesthesiologist are similar to the current criteria for payment of teaching surgeon services and the payment rule for the teaching surgeon involved in overlapping resident cases. Thus, there is a similarity in the payment rules for these physician specialties who work closely together.

(1) Payment for Anesthesia Services Furnished by a Physician

If the physician, usually an anesthesiologist, is involved in furnishing anesthesia services to a patient, the services can be furnished under one of three different scenarios. The anesthesiologist may—

• Personally perform the anesthesia services alone;

• Be involved in the case as a teaching anesthesiologist with an anesthesia resident; or

• Provide medical direction of the performance of anesthesia services for two, three or four concurrent cases involving a qualified individual (who may be a CRNA, an anesthesiologist assistant (AA), an anesthesia resident, or a student nurse anesthetist under certain circumstances).

Under the statute and CMS policy, if the anesthesiologist personally performs the anesthesia service alone or is involved in the case as a teaching anesthesiologist with an anesthesia resident, payment for the anesthesiologist's service is made at the regular fee schedule rate.

If the anesthesiologist furnishes medical direction for two, three or four concurrent anesthesia procedures, then payment for the anesthesiologist's service is made, in accordance with section 1848(a)(4)(B) of the Act, at 50 percent of the otherwise applicable fee schedule amount.

(2) Methodology for Payment of Anesthesia Services

Payment for anesthesia services furnished by a physician is made under the PFS, under section 1848(b)(2)(B) of the Act. The methodology for the calculation of the allowable amount is unique to anesthesia service only. Payment is made on the basis of anesthesia base units and time units, calculated from the actual anesthesia time of the case, instead of on the basis of work, PE, and malpractice RVUs. Payment for anesthesia services is also based on the anesthesia CF instead of the general PFS CF.

(3) Section 139(a) of the MIPPA

Section 139(a) of the MIPPA adds a new paragraph at section 1848(a)(6) of the Act to establish a "special payment rule for teaching anesthesiologists". This provision allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or in two concurrent anesthesia cases furnished on or after January 1, 2010. We will refer to anesthesia cases involving the training of residents as "resident cases" below in this section.

(4) Discussion

The Accreditation Council on Graduate Medical Education (ACGME) is a branch of the AMA, and it accredits allopathic residency programs. In order for a hospital to receive Medicare graduate medical education payments for its training programs, the residents must be in an "approved medical residency program" Under § 413.75(b), an approved medical residency program is one approved by one of the national organizations listed in § 415.152. One of the national organizations is the ACGME.

ACGME's policies and procedures require that each accredited residency program comply with the institutional requirements and the specialty program requirements. For approved anesthesia residency programs, ACGME requirements for faculty supervision and training of anesthesia residents specify that faculty members not direct anesthesia at more than two anesthetizing locations in the clinical setting. (See the ACGME Web site at http://www.acgme.org.)

Consistent with this requirement, the American Society of Anesthesiologists (ASA) has advised us that, when providing services in two concurrent cases, a teaching anesthesiologist might be engaged in two concurrent anesthesia resident cases, or in two mixed concurrent cases, one a resident case and the other a CRNA or AA case.

The statute applies the special payment rule for teaching anesthesiologists to the single resident case or two concurrent cases involving anesthesia residents as long as the teaching anesthesiologist meets the requirements in sections 1848(6)(A) and 1848(6)(B) of the Act. However, the statute does not directly address a single resident case that is concurrent to another case involving a CRNA, AA, or other qualified individual who can be medically directed. The issue is whether the medical direction payment rules apply to each of these cases or whether an alternative payment policy may apply.

One option in implementing this provision would be to strictly limit the special payment rule for teaching anesthesiologists to the single resident case (which is not concurrent to any other case) or the two concurrent resident cases (which are not concurrent to any other cases). For the mixed concurrent case, we could continue to apply our current medical direction payment policy to both the resident case and the other concurrent case. This would represent a continuation of our current medical direction payment policy, and would be predicated on the assumption that this is consistent with Congressional intent since the medical direction payment provisions at section 1848(a)(4) of the Act were left largely unchanged by section 139(a) of the MIPPA.

The other option would be to apply the special payment rule for teaching anesthesiologists to the resident case when it is concurrent to a medically directed case, and to apply the medical direction payment policy to the medically directed case. While this represents a broader interpretation, it still limits the applicability of the special payment rule for teaching anesthesiologists to resident cases consistent with the terms of section 139 of the MIPPA.

The special payment rule under section 1848(a)(6) of the Act clearly applies for two concurrent anesthesia resident cases. The ACGME requirements also allow the supervision of two concurrent cases, but are not specific regarding whether the requirements relate only to two resident cases, or also to mixed concurrent cases. However, both the statute and ACGME requirements seem amenable to a policy that would allow the special teaching payment rule to apply in mixed concurrent cases, that is, the single resident case that is concurrent to another case not involving a resident. Additionally, we are concerned that if we continued to apply the medical direction payment policy to mixed concurrent cases, then financial differences in payment policy might cause teaching anesthesiologists to make changes in the scheduling of mixed resident and CRNA cases. This might limit the utilization of CRNAs in certain scenarios.

Accordingly, we are proposing to delete the current regulatory language at § 414.46(e) (which is no longer relevant) and add new language to specify that the special payment rule for teaching anesthesiologists applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Other than the application of the special payment rule for teaching anesthesiologists in the mixed concurrent case described above, we are not proposing any other revisions to our medical direction payment policies.

- b. Teaching Anesthesiologists: Criteria for Payment
- (1) Criteria for Payment of Teaching Anesthesiologists

Currently, the teaching anesthesiologist can be paid at the

regular fee schedule rate for his or her involvement in a single resident case. As specified in § 415.178, the teaching anesthesiologist must be present with the anesthesia resident during all critical portions of the anesthesia procedure and be immediately available to furnish services during the entire procedure. Our manual instructions permit different physicians in the same anesthesia group to provide parts of the anesthesia service, and for the group to bill for the single anesthesia service. We refer to this practice as an "anesthesia handoff." (See Medicare Claims Processing Manual 100-04, Chapter 12, Section 50 C.) Of course, the medical record must document those individual physicians who furnished the services.

This manual instruction is not limited in scope to nonteaching hospitals. Thus, it is possible that teaching anesthesiologists have interpreted it to permit handoffs during resident cases.

Our manual instructions state that for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations (See Medicare Claims Processing Manual 100–04, Chapter 12, Section 100.1.2). It is our understanding that teaching surgeons do not hand off to another teaching surgeon during a key or critical portion of the surgical resident case.

(2) Section 139(a)(2) of the MIPPA

This section adds a new paragraph at section 1848(a)(6) of the Act which requires, in order for the special payment rule for teaching anesthesiologists to apply, that the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure. The new MIPPA provision regarding payment for services of a teaching anesthesiologist for two concurrent resident cases is similar to our current policy regarding payment for services of a teaching surgeon for two overlapping surgical resident cases.

(3) Discussion

The ASA has informed us that teaching anesthesiologists who work in the same anesthesia group sometimes provide different parts of the key or critical portions of a single anesthesia procedure. This type of a handoff situation might occur within an anesthesia group practice when there is an anesthesia procedure of long

duration, but would not be limited to that circumstance.

From a quality standpoint, we do not believe multiple handoffs among teaching anesthesiologists during a case that involves the training of an anesthesia resident would be optimal. We do not have data on the extent to which anesthesia handoffs occur during resident or other cases, or whether quality of anesthesia care is affected. We note that section 1848(a)(6)(A) of the Act refers only to "the" teaching anesthesiologist, and requires that the teaching anesthesiologist be present during all critical or key portions of the service. However, section 1848(a)(6)(B) of the Act seems to contemplate some level of handoffs between teaching anesthesiologists, at least between those who have entered into an arrangement for such handoffs.

One option would be to permit different anesthesiologists in the same anesthesia group practice to be considered "the teaching physician" for purposes of being present at the key or critical portions of the anesthesia case. (These physicians must have reassigned their benefits to the group practice in order for the group to bill.) Although this option would be less disruptive to the current anesthesia practice arrangements (as reported by the ASA), it would establish rules for teaching anesthesiologists that are different from those for teaching surgeons.

Another option would be to require that, in order to meet the requirement of section 1848(a)(6)(A) of the Act, only one individual teaching anesthesiologist must be present during all of the key or critical portions of the procedure. However, another teaching anesthesiologist with whom "the teaching anesthesiologist" under subparagraph (A) has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure in order to meet the requirement under subparagraph (B). We believe this is the most logical reading of the statute and would be consistent with the way the teaching surgeon payment policy is applied for overlapping surgical cases.

In addition to explaining available options for implementing this provision, we are also soliciting specific comments on how the continuity of care and the quality of anesthesia care are preserved during handoffs. We are interested in whether there is an accepted maximum number of handoffs and whether there are any industry studies that have examined this issue. We would like to hear from anesthesia practices that do not use handoffs and what procedures they have implemented to achieve this

result. Finally, we would like to know what factors or variables are contributing to anesthesia handoffs and what short term adjustments can be made to affect these factors.

Although we are interested in receiving comments on these topics, we are proposing to more narrowly interpret the law and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of the anesthesia procedure. We are also proposing that another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure.

c. Teaching CRNAs

(1) Payment for Anesthesia Services Furnished by a CRNA

Currently, a CRNA who provides anesthesia services while under the medical direction of an anesthesiologist is paid at 50 percent of the regular fee schedule rate as specified in section 1833(l)(4)(B)(iii) of the Act. A CRNA who provides anesthesia services without the medical direction of a physician is paid the regular fee schedule rate as specified in section 1833(l)(4)(A) of the Act.

(2) Payment for Anesthesia Services Furnished by a Teaching CRNA With a Student Nurse Anesthetist

The legislation that created the CRNA fee schedule payment system (that is, section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)) did not address payment for services furnished by teaching CRNAs involved in the training of student nurse anesthetists.

In the preamble to the CRNA fee schedule final rule published in the July 31, 1992 Federal Register (57 FR 33888), we stated that we would pay the teaching CRNA who is not medically directed by a physician at the regular fee schedule rate for his or her involvement in a single case with a student nurse anesthetist as long as he or she was present with the student throughout the anesthesia case. No payment would be made if the teaching CRNA divided his or her time between two concurrent cases involving student nurse anesthetists.

In August 2002, based on the recommendations of the American Association of Nurse Anesthetists (AANA), we modified our policy to allow the teaching CRNA not medically directed by a physician to be paid a portion of the regular fee schedule rate

for each of two concurrent cases involving student nurse anesthetists. If the teaching CRNA is present with the student nurse anesthetist during the preand post-anesthesia care for each of the cases involving student nurse anesthetists, the teaching CRNA can bill the full base units (comprised of preand post-anesthesia services not included in the anesthesia time units) for each case and the actual amount of anesthesia time per case. The resulting payment for each of these anesthesia cases is greater than 50 percent, but less than 100 percent, of the regular fee schedule amount because the full base units plus the actual anesthesia time units spent by the teaching CRNA in each of the two cases yields a payment that is greater than 50 percent of the regular fee schedule amount.

(3) Comparison of Payment Policies for Teaching CRNAs and Teaching Anesthesiologists

For several years, the American Society of Anesthesiologists (ASA) requested that we revise our payment regulations to allow the teaching anesthesiologist to be paid the regular fee schedule amount for each of two concurrent resident cases. In the CY 2004 PFS final rule with comment period (68 FR 63224), we finalized a policy to permit the teaching anesthesiologist to be paid similarly to a teaching CRNA for each of two concurrent resident cases. This policy took effect for services furnished on or after January 1, 2004.

Thus, the payment policy is the same for a teaching CRNA for each of two concurrent student nurse anesthetist cases, and for a teaching anesthesiologist for each of two concurrent resident cases. The policy is that the anesthesia provider is paid the full base units plus time units, based on the actual anesthesia time, relating to each of two concurrent cases.

(4) Payment Policy for an Anesthesiologist, or an Anesthesiologist and CRNA Jointly, With a Student Nurse Anesthetist

Currently, there are circumstances where an anesthesiologist may be involved in the training of student nurse anesthetists in two concurrent anesthesia cases. These anesthesia cases are not paid under the teaching anesthesiologist payment policy, but are paid under the usual medical direction payment policy. Payment can be made for the physician's medical direction (that is, 50 percent of the regular fee schedule amount) for each of two concurrent cases.

If an anesthesiologist is medically directing two concurrent cases involving student nurse anesthetists and a CRNA is also jointly involved with the two student nurse anesthetist cases, then the physician service, in each case, can be paid under the medical direction rules at 50 percent of the regular fee schedule. Payment for the CRNA services would also be made at the medically directed rate (that is, 50 percent of the regular fee schedule) for CRNA services, but the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in each case.

(5) Section 139(b) of the MIPPA

Section 139(b) of the MIPPA instructs the Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it—

• Is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA; and

 Maintains the existing payment differences between teaching anesthesiologists and teaching CRNAs.

We are proposing to implement the first directive (under section 139(b)(1) of the MIPPA) by establishing a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists, and to limit applicability of the rule to teaching CRNAs who are not medically directed. We are proposing to add a new regulation at § 414.61 to explain the conditions under which the special payment rule will apply and the method for calculating the amount of payment for anesthesia services furnished on or after January 1, 2010, by teaching CRNAs involved in the training of student nurse anesthetists. Under this proposal, we would pay the teaching CRNA at the regular fee schedule rate for each of two concurrent student nurse anesthetist cases. Our medical direction payment policy would continue to apply if both an anesthesiologist and a CRNA are involved in a student nurse anesthetist case that is concurrent to other anesthesia cases.

We believe the second directive in section 139(b)(2) of the MIPPA will be satisfied as a result of these proposals. Section 139(b)(1) of the MIPPA instructs CMS to make appropriate adjustments to implement a payment policy for teaching CRNAs that is consistent with the special payment rule for teaching anesthesiologists. Section 139(b)(2) of the MIPPA instructs CMS to maintain the existing payment differences between teaching anesthesiologists and teaching CRNAs. There currently are no substantive differences in payment

between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.

(6) Payment for Teaching CRNAs Involved in Anesthesia Cases With Student Nurse Anesthetists

Under current policy, when a CRNA is involved in a single student nurse anesthetist case, the teaching CRNA must be present with the student throughout the case in order to be paid at the regular fee schedule rate. We are not proposing any change to this policy.

When the teaching CRNA is involved in two concurrent student nurse anesthetist cases, payment is based on the amount of anesthesia time the teaching CRNA spends with the student in each case. For example, if the teaching CRNA spends 40 percent of his or her time in concurrent case #1 and 60 percent of his or her time in concurrent case #2, and the total anesthesia time in both cases is 3 hours (or 180 minutes), then we would currently pay as follows:

• Case #1: (Base units + (0.4 × 180/ 15)) × Anesthesia CF

• Case #2: (Base units + $(0.6 \times 180/15)$) × Anesthesia CF

The current payment policy has been predicated on paying the teaching CRNA for his or her actual time spent in the student nurse anesthetist case. We are now proposing to pay the teaching CRNA at the regular fee schedule rate for his or her involvement in two concurrent cases. If our goal is to minimize the effect of this change on teaching CRNAs' practice arrangements and time devoted to cases, then we would propose that the teaching CRNA continue to devote 100 percent of his or her time to the two concurrent cases. The teaching CRNA would decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status, and other factors.

An alternative to this policy would be to apply the same criteria for teaching CRNAs as we use in § 415.178 with respect to teaching anesthesiologists. These criteria require the teaching anesthesiologist to be present during all critical or key portions of the anesthesia service. However, we believe these criteria are relevant and appropriate only for teaching anesthesiologists due to significant differences in experience, education and other qualifications between anesthesia residents and student nurse anesthetists. The anesthesia resident has completed medical school and is typically a

licensed physician. In contrast, the student nurse anesthetist is an RN who usually has some clinical experience in ICU or critical care nursing prior to starting the CRNA training program. Thus, we believe the resident is more qualified through medical training and education than the student nurse anesthetist to provide elements of the anesthesia service without the immediate presence of the teaching anesthesiologist. Therefore, we propose to retain our current policy.

We note that the Congress did not amend the statutory provisions relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to other arrangements in which anesthesiologists alone or both anesthesiologists and CRNAs jointly supervise student nurse anesthetists during concurrent anesthesia cases. Therefore, we are not proposing any changes to our current payment policies for anesthesia services furnished under other circumstances. We are proposing that when an anesthesia provider (physician or CRNA) furnishes anesthesia services in concurrent cases under other circumstances, the current policies regarding medical direction will continue to apply.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services

Section 144(a) of the MIPPA amended Title XVIII of the Act, in pertinent part, to provide for coverage of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) under Medicare Part B. The statute specifies certain conditions for these services, with coverage to begin on January 1, 2010. The addition of the new CR and ICR programs is designed to improve the health care of Medicare beneficiaries with cardiovascular disease. This proposed rule implements these MIPPA provisions in order to ensure services enhance the patient's clinical outcomes.

a. Background

Intensive cardiac rehabilitation (ICR) is a relatively new practice that is also commonly referred to as a "lifestyle modification" program. These programs typically involve the same elements as general CR programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and also may be more rigorous.

b. Cardiac Rehabilitation Coverage Under Medicare

One mechanism we use to establish coverage for certain items and services is the national coverage determination (NCD) process. An NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII.

Since 1982, Medicare has covered, under an NCD, cardiac rehabilitation for patients who experience stable angina, have had coronary artery bypass grafts, or have had an acute myocardial infarction within the past 12 months. The NCD is located in the Medicare NCD Manual (Pub. 100–03), section 20.10. Effective March 22, 2006, we modified the NCD language to cover comprehensive cardiac rehabilitation programs for patients who experience one of the following:

- A documented diagnosis of acute myocardial infarction within the preceding 12 months.
 - A coronary bypass surgery.
 - Stable angina pectoris.
 - A heart valve repair/replacement.
- A percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.

 A heart or heart-lung transplant. Comprehensive programs must include a medical evaluation, a program to modify cardiac risk factors, prescribed exercise, education, and counseling and may last for up to 36 sessions over 18 weeks or no more than 72 sessions over 36 weeks if determined appropriate by the local Medicare contractors. Facilities furnishing cardiac rehabilitation must have immediately available necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment and be staffed with personnel necessary to conduct the program safely and effectively who are trained in advanced life support techniques and exercise therapy for coronary disease. The program must also be under the direct supervision of a physician. Until section 144(a) of the MIPPA is effective, ICR programs are covered under this NCD and are subject to the same coverage requirements.

We are proposing to implement section 144(a) of the MIPPA and refine coverage for CR and ICR through this rulemaking process. When the rulemaking is completed, we will take the necessary steps to withdraw and/or modify the NCD.

c. Statutory Authority

Section 144(a) of the MIPPA amended the Medicare Part B program by adding new sections 1861(s)(2)(CC) and 1861(s)(2)(DD) of the Act to include items and services furnished under a "cardiac rehabilitation program" and an "intensive cardiac rehabilitation program," respectively. A cardiac rehabilitation program is defined in new section 1861(eee)(1) of the Act and an intensive cardiac rehabilitation program is defined in new section 1861(eee)(4)(A) of the Act.

A cardiac rehabilitation program is a physician-supervised program that furnishes the following: Physicianprescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; outcomes assessment; and other items or services as determined by the Secretary under certain conditions. These items and services must be furnished in a physician's office, in a hospital on an outpatient basis, or in other settings as determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and emergencies at all times items and services are being furnished in a CR program except when provided in a hospital setting where such availability is presumed. The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. These written plans must be established, reviewed, and signed by a physician every 30 days.

We are proposing that ICR programs must provide the same items and services under the same conditions as CR programs but must demonstrate, as shown in peer-reviewed published research, that they have accomplished one or more of the following: Positively affected the progression of coronary heart disease, or reduced the need for coronary bypass surgery, or reduced the need for percutaneous coronary interventions (PCIs). The peer-reviewed published research must also show that the ICR program has resulted in a statistically significant reduction in 5 or more measures from their levels before ICR services to their levels after receipt of such services. These measures include low density lipoprotein; triglycerides; body mass index; systolic blood pressure; diastolic blood pressure; or the need for cholesterol, blood pressure, and diabetes medications.

Beneficiaries eligible for ICR must have experienced the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. Section 1861(eee)(4)(C) of the Act, as added by section 144(a)(1)(B) of the MIPPA, states that an ICR program may be provided in a series of 72, 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

The statute directs the Secretary to establish standards for the physician(s) supervising the ICR and/or CR programs to ensure that the physician has expertise in the management of individuals with cardiac pathophysiology and is licensed by the State in which the CR program (or ICR program) is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

d. Proposals for Implementation

We are proposing to create new § 410.49, "Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage."

(1) Definitions

In this section, we are proposing several definitions for the terms used with respect to the programs and services required by section 144(a) of the MIPPA. These terms include the following:

- Cardiac rehabilitation program.
- Individualized treatment plan.
- Intensive cardiac rehabilitation.
- Physician.
- Physician-prescribed exercise
- Psychosocial assessment.
- · Outcomes assessment.

(2) Covered Beneficiaries

In § 410.49, we are proposing to establish coverage for CR and ICR programs for beneficiaries who have experienced any of the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. We are proposing to maintain and refine coverage of general CR programs for beneficiaries with these six conditions as originally established in Pub. 100-03, section 20.10 as this coverage was determined to be reasonable and necessary under section 1862(a)(1)(A) of the Act due to a high level of supporting clinical evidence. We are also proposing through this rulemaking to use the NCD process in the future to identify

additional medical indications for patients who could obtain CR under Medicare Part B. While CR programs include certain mandatory services, the written plans are highly individualized, and we propose to allow some flexibility in the type, amount, frequency, and duration of services provided in each session. However, as supported by medical literature and statements of the American Heart Association (AHA) and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR),4 aerobic exercise training using the muscles of ambulation is a mandatory component of any CR or ICR program. We recommend both low- and highintensity exercise to produce optimal benefits, and suggest a combination of endurance, strengthening and stretching exercises. Patients in general CR programs must participate in a minimum of 2, 1-hour CR sessions a week, and a maximum of 2, 1-hour sessions a day. Patients in ICR programs may participate in up to 6, 1-hour sessions per day not to exceed 72, 1hour sessions over an 18-week period. By a 1-hour session, we mean that each session must last a minimum of 60 minutes. Each day CR or ICR items and services are provided to a patient, aerobic exercises along with other exercises must be included (that is, a patient must exercise aerobically every day he or she attends a CR or ICR session). Exercise may include the use of treadmills, bicycles, light weights or other equipment, and should be intended to improve cardiovascular function, strength, endurance, and flexibility.

Section 144(a) of the MIPPA requires CR and ICR programs to furnish items and services including "cardiac risk factor modification." This includes education, counseling, and behavioral intervention to the extent these services are closely related to the individual's care and treatment and tailored to patients' individual needs. We are proposing that patients must be provided with the information and tools to improve their overall cardiovascular health. Items and services furnished as part of the risk factor modification component should be highly

⁴ Balady G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. Journal of Cardiopulmonary Rehabilitation and Prevention 2007;27:121–129.

individualized as multiple risk factors contribute to poor cardiovascular health. For example, these items and services may include smoking cessation counseling or referral, nutritional education and meal planning, stress management, prescription drug education and management information, disease history education in order to foster a better understanding of disease origins and disease symptomatology, and any other education, counseling and behavioral intervention deemed appropriate in each patient's individualized treatment plan.

The MIPPA provisions require a psychosocial assessment as part of the CR and ICR programs defined above. We are proposing that the initial assessment by program staff evaluate aspects of the individual's family and home situation that may affect their treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Prior to each 30-day review of the individualized treatment plan, the supervising physician or program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assist in ensuring that patients begin CR with a program tailored to their needs, a periodic re-evaluation is necessary to ensure that their psychosocial needs are in fact being met.

The MIPPA provisions also require that CR and ICR programs include outcomes assessment. Professional groups, such as the AHA and AACVPR, recognize a number of relevant patient outcomes that may be expected to accrue from the various components of cardiac rehabilitation.5 We propose to define outcomes assessment as an evaluation of the patient's progress in the program using assessments from the commencement and conclusion of CR and ICR programs that are based upon patient centered outcomes. Patient centered outcomes must be measured at the beginning of the CR program, prior to each 30-day review of the individualized treatment plan, and at the end of the CR program. All

assessments are considered part of the CR program and, as such, are conducted in the appropriate settings and not billed separately. These measures should include resting and exercising heart rate, resting and exercising systolic and diastolic blood pressure, weight, BMI, amount and dosage of medications required, self-reported quality of life, and behavioral measures (for example, smoking cessation, increased activity levels, change in exercise levels during CR). As CR programs must be highly individualized, alternate or additional measures may be appropriate. Patients' individualized treatment plans should be altered accordingly with changes and/or progress in each of the outcome measurements. Programs may also develop performance standards which measure the overall quality of the program, by assessing the group as a whole.

The MIPPA provisions require that CR services be provided under written individualized treatment plans. As CR programs are highly individualized, we propose that the physician define and set the parameters, including the individual's diagnosis, the types of services appropriate, and the treatment goals. The MIPPA provisions require the physician to establish the written individualized treatment plan and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the CR physician. If the plan is developed by the referring physician who is not the CR physician, the CR physician must also review and sign the plan prior to initiation of CR. Direct physician contact is not always required to meet the 30-day review standards, but might be necessary depending upon specific patient factors. Regardless, CR staff must provide both outcome and psychosocial assessments to the supervising physician prior to the 30day deadline and the physician must evaluate the information provided by the CR staff. The CR staff may make recommendations for modifications to the program, but the physician will still modify the plan as needed, and review and sign the plan. The MIPPA provisions require written specificity relating to the type, amount, frequency, and duration of the items and services furnished under the individual's plan. As CR patients have had or may develop disabling cardiovascular disease, they require individual attention and assessments that address their individualized needs and meet realistic individualized goals through a specifically designed treatment plan.

The individualized treatment plan should specify the combination of services necessary to address the patient's needs, as identified through the initial assessment and based upon changes in the patient's condition. It must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the individualized treatment plan should be consistent with current evidence-based professionally-accepted clinical practice standards such as those identified by the AHA and AACVPR.

The MIPPA provisions also authorize the Secretary to include other mandatory items and services within the scope of the CR program under certain conditions. We are not proposing to require any other items and services at the present time. If the Secretary determines that the addition of any other items and services is appropriate, additions will be made and implemented through future

rulemaking.

Section 144(a) of the MIPPA provides for coverage of CR and ICR services in various settings which include a physician's office, a hospital on an outpatient basis or other settings determined appropriate by the Secretary. We are not proposing to cover CR or ICR in other settings at this time. If the Secretary determines that the addition of settings is appropriate, additions will be made through rulemaking. All settings should have all equipment and staff necessary, consistent with cardiac rehabilitation professional society recommendations, to provide statutorily-mandated items and services.

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. Professional groups such as the AHA and AACVPR recognize the need to provide appropriate patient supervision and, where appropriate, monitoring. We are proposing that such availability be met through existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish

 $^{^{\}rm 5}\, \rm Balady$ G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. Journal of Cardiopulmonary Rehabilitation and Prevention 2007:27:121-129.

assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies

and medical emergencies. For CR and ICR services provided in physicians' offices and other Part B settings paid under the PFS, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with the § 410.26(b)(5). This does not mean that the physician must be in the room when the service or procedure is performed. For CR and ICR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services furnished in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is furnished. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of cardiac rehabilitation

The MIPPA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption relating to direct physician supervision for hospital outpatient services means that direct physician supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals, and we expect that hospitals are providing services in accordance with this standard.

services at that time.

New section 1861(eee)(4) of the Act requires ICR programs, to be qualified for Medicare coverage, to meet several standards. To become qualified, an ICR program must demonstrate through peer-reviewed, published research that

it has accomplished one or more of the following: (1) Positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; or (3) reduced the need for percutaneous coronary interventions (PCIs). A qualified ICR program must also demonstrate through peer-reviewed published research that the ICR program accomplished a statistically significant reduction for patients in 5 or more specific measures from the individual's levels before ICR services to their levels after receipt of such services. These measures include: (1) Low density lipoproteins; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. To ensure that ICR programs in fact meet these standards, we are proposing that programs intending to operate as ICR programs apply to CMS to receive designation as qualified ICR programs. Only designated programs would then be eligible for Medicare coverage and would be required to undergo regular reevaluation to maintain such status. We are requesting public comments on establishing an annual re-evaluation process.

We are proposing that programs may apply to CMS to be designated qualified programs to provide ICR. To meet this designation, programs must submit to CMS detailed literature describing the program and the precise manner in which the program meets MIPPA provisions. Each program must also submit peer-reviewed, published research specific to the actual program applying for approval. The research must clearly demonstrate that the program under examination accomplishes at least the minimum outcomes as defined above. We are proposing, based on our general rulemaking authority that each ICR program must submit a detailed description of the items and services available to ICR patients and the capabilities of the facility in which the program takes place as well as the responsibilities of program staff. All materials shall be submitted to: Director, Coverage and Analysis Group, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1-09-06, Baltimore, Maryland 21244.

Following CMS review, ICR programs will either be notified of any missing information or inadequacies in their submissions (so they may resubmit in the future) or be notified of CMS designation as an ICR program. Designated programs will be identified in a list of ICR programs posted on the CMS Web site and in the **Federal**

Register. We are proposing that all designated programs must demonstrate continued compliance with MIPPA standards every year in order to maintain qualified status.

We are proposing that for an ICR program to maintain its designation by CMS as a qualified ICR program, the program must submit specific outcomes assessment information. Programs shall submit information for all patients who initiated and completed the full ICR program during the initial year-long CMS designation. For each patient, programs must identify the following: (1) The medical condition qualifying the patient for eligibility to participate in ICR; (2) the patient's improvement in coronary heart disease, reduced need for coronary bypass surgery, and/or reduced need for PCIs; and (3) the levels of the 5 or more measures identified above at the beginning and end of the program. Programs must also submit average beginning and ending levels of at least those 5 measures for the program as a whole. If any changes are made to the ICR program during the initial year-long CMS designation, such changes must be documented and submitted with the outcomes assessment information. Programs will have 30 days to submit this information to CMS following the end of the initial approval period. In the month following receipt, we will review the submitted information and determine whether the program continues to meet the payment standards. We believe that reevaluations of designated programs will assist CMS in ensuring that programs continue to demonstrate the outcome measures identified for initial designation. We are requesting public comments on annual program reevaluations requirements, the required information for re-evaluation proposed above and if an administrative appeals process should be established for ICR programs that no longer meet outcomes standards. We are also asking for public comments on the time period for reevaluations of ICR programs.

Section 144(a)(1)(B) of the MIPPA requires CR and ICR programs to be physician-supervised. In addition, section 144(a)(5) of the MIPPA requires the Secretary to establish standards to ensure that the physician, who has the appropriate expertise in the management of individuals with cardiac pathophysiology and is licensed to practice medicine in the State in which the CR or ICR program is offered, is responsible for the CR or ICR program. We propose to identify this physician who oversees or supervises the CR and ICR program in its entirety as the Medical Director. As required by

144(a)(5), we are proposing that the Medical Director must have training and proficiency in cardiovascular disease management and exercise training of heart disease patients. We also propose that the Medical Director, in consultation with other staff, must be involved substantially in directing the progress of individuals in the program. We are expressly seeking public comments on the precise level of expertise that is necessary for the Medical Director.

As discussed above, section 144(a)(2)(B) of MIPAA requires that a physician must be immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the program. For purposes of this proposed rule we are identifying this physician as the supervising physician (that is, the physician that must be immediately available to furnish assistance and direction throughout the performance of CR and ICR services); we believe this physician also requires expertise in cardiac pathophysiology resulting from training or experience in cardiovascular disease management and exercise training of heart disease patients. This includes a physician billing Medicare Part B for providing services directly to a patient during a CR or ICR session. We are proposing standards for these physicians based on our general rulemaking authority which include expertise in the management of individuals with cardiac pathophysiology and licensure to practice medicine in the State in which the CR or ICR program is offered. We are expressly inviting public comments about the precise level of expertise that is necessary.

Please note that the program Medical Director may fulfill both roles of Medical Director and supervising physician (of individual CR and ICR services furnished to patients) provided that the requirements for direct physician supervision as required in §§ 410.26 and 410.27 are met when CR or ICR items and services are furnished, as discussed above.

We are requesting public comments regarding whether specific training and expertise standards are needed for the cardiac rehabilitation staff.

Section 1861(eee)(4)(C) of the Act provides for coverage of ICR programs that are provided in a series of 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks. Specific provisions for the number, duration, and time period for general CR programs are not identified in the

MIPPA; however we propose to maintain, with slight refinements, coverage requirements previously established in Pub. L. 100-03, section 20.10 through this rulemaking process. For eligible beneficiaries, general CR is provided for up to 36 1-hour sessions, up to 2 sessions per day with no fewer than 2 sessions per week, over up to 18 weeks, with contractor discretion to expand these limitations to not exceed 72 sessions for 36 weeks. This is based on section 1862(a)(1)(A) of the Act and our general rulemaking authority. By 1hour session, we mean that each session must last a minimum of 60 minutes.

e. Coding and Payment

(1) CR Payment

Currently, the following CPT codes are used for CR services described in section 144(a) of the MIPPA: CPT code 93797, Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and CPT code 93798, Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session). We are not proposing to revise these codes under the PFS because the CR program authorized by the existing NCD is essentially the same as that included in the MIPPA.

(2) ICR Payment

The statute requires that the hospital Outpatient Prospective Payment System (OPPS) payment amount for CR services be substituted for ICR under the PFS, specifically the payment for CPT codes 93797 and 93798 or any succeeding HCPCS codes for CR. We are proposing to create two new HCPCS codes for ICR services. These codes may only be billed by ICR programs that have been approved by CMS. The proposed codes are as follows:

- GXX28, Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session.
- GXX29, Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session.

These HCPCS codes will be recognized under the PFS and the OPPS. Under the OPPS the existing CR HCPCS codes, CPT codes 93797 and 93798, are assigned to APC 0095 (Cardiac Rehabilitation) for CY 2009. Because the payment under the PFS for the two proposed ICR G-codes is required to be the same as the payment for CR services under OPPS, we are proposing to pay the same amount as will be established through rulemaking

for CY 2010. The proposed OPPS payment amount for CR services will be announced in the CY 2010 OPPS/ASC proposed rule. We are proposing that this amount will be adjusted for the appropriate locality by applying the GPCI under the PFS. The CY 2010 proposed APC assignments and payment rates for these two ICR G-codes will be published in the CY 2010 OPPS/ASC proposed rule. The proposed payment rate for the associated APC(s) will be included in Addendum A to the CY 2010 OPPS/ASC proposed rule.

We note that when a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill the Medicare contractor for CR/ICR unless the physician personally performs the CR/ICR service. To personally perform the CR/ICR service, the physician would provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital would report the CR/ICR service and be paid the OPPS payment for the facility services associated with the CR/ICR session and the physician would report and be paid the PFS amount for the CR/ ICR service. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others. If the physician furnishes no direct CR/ ICR services for a given session or on a given day or provides direct CR/ICR services for less than the full session, then only the hospital would report the CR/ICR services and these services would be paid under the OPPS.

9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services

Section 144 of the MIPPA amended Title XVIII of the Act to provide for coverage of pulmonary rehabilitation (PR) under Part B, under certain conditions, for services furnished on or after January 1, 2010. This proposed rule would implement the new Medicare pulmonary rehabilitation program and establish the requirements for providing such services to Medicare beneficiaries with a diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD). COPD is not only one of the more common of the diseases in the category of chronic respiratory diseases, it is one of the more severely debilitating, characterized by chronic bronchitis and emphysema. Other diseases and conditions in this category include persistent asthma, bronchiectasis, primary pulmonary hypertension, obesity-related respiratory disease, and ventilator dependency. This rule provides direction in implementing the MIPPA in order to ensure services are covered and enhance the patient's clinical outcomes.

a. Background

A PR program is typically a multidisciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy. The main goal of an individualized PR training program is to empower and facilitate the individuals' ability to exercise independently; exercise is the cornerstone of the PR program. Exercise is combined with other training and support mechanisms necessary to integrate prevention and encourage long-term adherence to the treatment plan. The appropriate PR program will train and motivate the patient to his or her maximum potential in self-care, and improve his or her overall quality of life.

b. Provisions of Section 144 of the MIPPA

In pertinent part, section 144 of the MIPPA amended section 1861(s)(2) of the Act to add a new subparagraph (CC) establishing coverage of items and services furnished under a "pulmonary rehabilitation program." Pulmonary rehabilitation program is defined in new subsection (fff)(1) to mean a physician supervised program that furnishes several specific items and services. These include all of the following:

- Physician-prescribed exercise.
- Education or training (to the extent that the education and training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs).
 - Psychosocial assessment.
 - Outcomes assessment.
- Other items and services determined by the Secretary to be appropriate under certain conditions.

These components are to be provided in physicians' offices, hospital outpatient settings, and other settings determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and medical emergencies at all times when PR items and services are being furnished under the program. The individual's treatment is furnished under a written treatment plan that is developed by the physician for each beneficiary participating in a PR program. A physician must establish and review the plan and it must be signed by the physician every 30 days. This plan must include the individual's diagnosis, the scope of services to be

provided in terms of type, amount, frequency and duration, and the goals set for the individual. To be covered and paid by Medicare, the PR program must provide all of the specified mandatory items and services. With respect to the Secretary's authority to require additional items and services, we are not proposing any additional services at the present time; however, we may propose additional items and services in the future.

c. Proposals

Under section 144 of the MIPPA, we are proposing to create a new § 410.47, "Pulmonary Rehabilitation Program: Conditions for Coverage" under Part B to add the PR program as a Medicarecovered service. The new section 1861(fff) of the Act outlines the mandatory components of a PR program. In accordance with this new section, any facility providing a PR program must meet all of the requirements outlined herein. The MIPPA provides for coverage of PR services in two specific settings (physician's office, hospital outpatient) and authorized the agency to consider the addition of other settings. We are not proposing any other settings at the present time.

The PR provisions defined by section 144 of the MIPPA are effective January 1, 2010.

(1) Definitions

We are proposing the following definitions for the programs and services required by MIPPA as related to PR provisions.

- Individualized treatment plan: A written plan which describes the individual's diagnosis; the type, amount, frequency and duration of the items and services to be furnished under the plan, including specifics related to the individual's particular needs for education and training; and the goals set for the individual under the plan.
- Outcomes assessment: A
 physician's evaluation of the patient's
 progress as it relates to his or her
 rehabilitation. The outcomes assessment
 is in writing and includes the following:
 (1) Pre- and post-assessments, based on
 patient-centered outcomes which are
 conducted by the physician at the
 beginning of the program and at the end
 of the program; and (2) objective clinical
 measures of exercise performance and
 self-reported measures of shortness of
 breath and behavior.
- *Physician:* A doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.
- *Physician-prescribed exercise:* Physical activity, including aerobic

exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

• Psychosocial assessment: A written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

This includes: (1) An assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment; and (2) a psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

• Pulmonary rehabilitation: A short term physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(2) Coverage

We are proposing that Medicare Part B would cover PR for beneficiaries with moderate to severe COPD when ordered by the physician treating chronic respiratory diseases. A comprehensive PR program may be adapted for any person with chronic respiratory disease. The medical literature describes conditions associated with the possible need for PR including COPD, obesity-related respiratory disease, lung cancer, and neuromuscular diseases. However, the benefits of a PR program most strongly support its use for patients with moderate to severe COPD.

(a) Definition of Moderate to Severe COPD

Moderate to severe COPD is defined as GOLD classification II and III. The GOLD classification utilizes indices that measure airflow limitation and lung hyperinflation to determine severity of COPD. Specifically, the measurement of Forced Expiratory Volume (FEV) in the first second divided by the Forced Expiratory Vital Capacity (liters) (FEV1/ FVC) gives a clinically useful index of airflow limitation. In other words, the volume of air exhaled that can be forced out in one second after taking a deep breath divided by the maximum volume of air exhaled as rapidly, forcefully and completely as possible from the point of maximum inhalation equals a numerical value used to grade COPD severity. Moderate and severe COPD are defined

- GOLD classification II (Moderate COPD)) is defined as FEV1/FVC<70 percent and FEV1 ≥30 percent to <80 percent predicted with or without chronic symptoms (Cough, sputum production, dyspnea).
- GOLD classification III (Severe COPD) is defined as FEV1/FVC < 70

percent and FEV1 < 30 percent predicted or FEV1 < 50 percent predicted plus respiratory failure or clinical signs of right heart failure.

Section 144 of the MIPPA does not specify the medical conditions for which coverage and payment are authorized for a PR program, other than a reference in the title to "chronic obstructive pulmonary disease and other conditions". Although the spectrum of possible conditions for which PR may be covered is broad, the medical guidelines most strongly supported the benefits of a PR program for individuals with moderate to severe COPD. The major national and international respiratory organizations (that is, ATS/ERS, the American College of Chest Physicians (AACP) jointly with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), and Global Initiative for Chronic Obstructive Lung Disease) have recommended PR as the standard of care in the treatment of moderate to severe chronic obstructive pulmonary disease represented by GOLD classification II or III. Because there is not data to substantiate significantly improved outcomes for any other medical conditions, we are proposing to allow moderate to severe COPD as the only covered condition. We propose to consider expanding coverage to patients with other medical conditions, should evidence support these additional uses. We would propose in our regulations to use the national coverage determination process to consider expanding coverage of PR for other chronic respiratory.

(b) Use of the NCD Process

We are proposing to use the national coverage determination process as authorized by section 1871(1) of the Act, to consider expanding coverage to items and services furnished by PR programs. The NCD process is open and transparent and provides an opportunity for public comments. Moreover, the NCD process affords CMS the ability to conduct a timely assessment of recent clinical evidence through a flexible and transparent process. It allows us to make uniform nationwide coverage determinations for items and services in a more flexible manner than rulemaking. In most circumstances, the NCD process is required to be completed within 9 to 12 months of the time that we accept a formal request for an NCD on a particular service. The NCD process will maximize the clinical benefit of PR for beneficiaries, and permit more rapid changes in response to emerging clinical evidence.

(3) Physician-Prescribed Exercise

Since the determination of the optimal time spent on each of the specific components within a PR program is highly individualized under the written plan of care, we are proposing to give the program medical director considerable flexibility. However, aerobic exercise is widely considered the cornerstone of pulmonary rehabilitation, and practice guidelines in the medical literature suggest exercise training of the muscles of ambulation as an essential component of a PR program. Each session must include some physicianprescribed aerobic exercise. We recommend both low- and highintensity exercise to produce clinical benefits. It is suggested that exercise sessions involving a combination of endurance and strength training (to increase muscle strength and muscle mass) be conducted at least twice per week to achieve physiological benefits. Exercise may include use of treadmills, bicycles or other equipment, and should provide increased pulmonary function, strength, endurance, and flexibility.

(4) Education or Training Under the PR Program

Section 144 requires that education or training must meet the statutory requirements that mandate that it must be closely and clearly related to the individual's care and treatment, as well as meeting the specific needs of the individual. As part of the written individualized treatment plan the physician should evaluate and include only that education and training which addresses the needs particular to the patient that will further their independence in activities of daily living. The training and education prescribed should assist patients in learning to adapt to their limitations and improve the quality of their lives. Patients with COPD often use respiratory therapy modalities and equipment to aid their breathing. Education and training should be provided as necessary to ensure proper use and compliance with the physician's prescription. Instruction should include proper use, care, and cleaning of home respiratory equipment. Examples of equipment for which instruction would be appropriate include nebulizers/compressors, transtracheal oxygen (TTO), peak flow meters, and oxygen-conserving devices. Current medical literature provides for education as an integral component of pulmonary rehabilitation. The supervising physician must ensure the education or training helps further the

primary objective of understanding and self-management of the chronic respiratory disease, specifically focused on COPD, including educational information on prevention and treatment of exacerbations. Examples of training sessions include those on respiratory techniques for physical energy conservation, work simplification, and relaxation techniques. Skills training and education also encourage behavioral changes by the patient, which can lead to improved health and long-term adherence. For example, brief smoking cessation counseling, as appropriate and respiratory problem management, should be included. Other topics for education may include the proper use of medications and nutrition counseling.

(5) Psychosocial Assessment

Section 144 of the MIPPA requires a psychosocial assessment as part of the PR program; we propose that it should be a written assessment. The initial assessment by program staff will evaluate aspects of the individual's family and home situation that may affect his or her treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Individual psychological considerations will also be addressed. For example, smoking is well known to be a cause of COPD. Depression and anxiety are commonly reported concerns for this patient population. Psychosocial intervention could help facilitate behavioral changes, such as smoking cessation, as well as assist with managing symptoms such as dyspnea. The assessment should include a written evaluation of the patient's need, as appropriate, for depression management, stress reduction, relaxation techniques, and strategies for coping with lung disease. This proposed rule does not propose any changes to the existing NCD (210.4) for "Smoking and Tobacco-Use Cessation Counseling."

The psychosocial assessment should include thorough screening and evaluation of the individual's lifestyle and other behaviors. Prior to each 30day review of the individualized treatment plan, the program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assure that patients begin PR with a program tailored to their needs, periodic re-evaluations are necessary to ensure that their psychosocial needs are in fact

being met.

(6) Outcomes Assessment

Section 144 of the MIPPA also requires that the PR program include outcomes assessment. In this proposed rule, we define outcomes assessment as an objective clinical measure of the effectiveness of the PR program for the individual patient. Patient-centered outcomes should be measured at the beginning of the PR program, prior to each 30-day review of the individualized treatment plan, and no later than at the end of the PR program. All such assessments are considered part of the PR program and as such are conducted in the appropriate settings and may not be billed separately. These measures should include clinical measures such as a 6-minute walk, weight, exercise performance, selfreported dyspnea (exertional and with daily activities), behavioral measures (supplemental oxygen use, smoking status), and a quality-of-life assessment. Some of the common program outcome measures examined in PR are functional exercise capacity, survival, and ADLs.

(7) Individualized Treatment Plan

Section 144 of the MIPPA requires that the physician develop, sign, and review an individualized treatment plan. In recognizing that PR programs are inherently highly individualized, we are proposing that the physician shall define and set the parameters, including types, amount, frequency and duration of the services, and goals, for the individual's treatment plan that include each of the four component services within the maximum duration of the program. The MIPPA requires the physician to establish the written individualized treatment plan at the start of the program and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR. We would expect the supervising physician to have initial direct contact with the individual prior to subsequent treatment by auxiliary personnel. We would also expect at least one direct contact with the beneficiary in each 30day period. Regardless, PR staff must provide both outcome and psychosocial assessments to the responsible physician prior to the 30-day deadline. Even if the PR staff makes recommendations for modifications to the program the physician will still be responsible for modifying the plan as needed, and reviewing and signing the plan prior to implementation for the

individual. The MIPPA also requires written specificity relating to the type, amount, frequency and duration of items, and services furnished to the individual. Patients with chronic respiratory disease require individual attention, and assessments which address individualized needs must be designed to meet realistic individual goals. Therefore, the individualized plan of care should specify the mix of services necessary to address the patient's needs, as identified through the initial assessment, and based upon changes in the patient's condition. Further, it must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care should be consistent with current evidence-based professionallyaccepted clinical practice standards.

(8) Settings

In the MIPPA, the Congress has identified 2 appropriate settings for pulmonary rehabilitation, and also authorized the agency to provide additional settings for the PR program. We considered whether these new requirements should extend to CORFs, which are governed by different statutory provisions in section 1861(cc) of the Act. Given the differences in the statutory language, we do not propose extending the PR program requirements to CORFs. Individuals requiring PR program services have a chronic respiratory disease and are in need of supervised aerobic exercise, not physical therapy. Conversely, in the CORF setting physical therapy is the cornerstone component and a mandatory service, while exercise is not. Thus, the PR program is for an inherently different patient population, and allows for the first time, payment for exercise for COPD patients. Therefore, we propose not to include the CORF as a setting for a PR program. The respiratory therapy services performed in a CORF are part of a CORF program of services and not part of a PR program. We would consider the inclusion of additional settings through future rulemaking.

Both physician offices and outpatient settings must meet the standards as defined in the rule for safety and emergency care. These include both the immediate availability of the physician during the PR program and certain equipment requirements. In order to ensure proper safeguards in the statutorily-prescribed settings, the setting must have the cardio-pulmonary, emergency diagnostic and therapeutic equipment accepted as medically necessary by the medical community for

emergency treatment related to a chronic respiratory disease condition. Some examples of this equipment are oxygen, defibrillators, and cardio-pulmonary resuscitation equipment. The setting must have all equipment and staff necessary to provide all of the statutorily-mandated items and services. We would expect that any additional settings which may be added through future rulemaking would similarly need to meet all of the aforementioned requirements.

(9) Physician Supervision

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. We are proposing to define such availability in accordance with existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because a physician must be present and immediately available where the services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For PR services furnished in physicians' offices and other Part B settings paid under the PFS, this means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with $\S 410.26(\bar{b})(5)$. It does not mean that the physician must be in the room when the service or procedure is performed. For PR services provided to ĥospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services provided in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the providerbased department) and immediately available to furnish assistance and

direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is performed. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of pulmonary rehabilitation services at that time.

The MIPAA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption of direct physician supervision for hospital outpatient services means that direct physician supervision is the standard and we expect that hospitals are providing services in accordance with this standard.

(10) Physician Standards

The MIPPA authorizes the Secretary to establish standards to ensure that only a physician with expertise in the management of individuals with respiratory pathophysiology and who is licensed by the State where the PR program is offered shall be responsible for the program and direct the individual's progress. We propose to identify the physician who oversees or supervises the PR program in its entirety as the program medical director, and this may be the same physician providing, and billing for, the PR services. We are proposing that the program medical director must have training and proficiency in chronic respiratory disease management and exercise training of chronic respiratory disease patients. We further propose that the standards for program oversight shall include substantial involvement in the monitoring and direction of the patients' progress, and by implication, the staff that assists in furnishing the services. As part of his or her responsibility and accountability for the program, the program medical director will be expected to retain all records and documentation for each beneficiary which are ordinarily compiled in their clinical practice. We propose that the substantiation of the program medical director's expertise in respiratory pathophysiology would correlate to experience in the provision of care for individuals with chronic respiratory diseases. For purposes of referral for PR services, we are proposing to use the definition of "physician" specified in section 1861(r)(1) of the Act which

defines "physician" as "a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) of the Act)." We also propose that a supervising physician must be immediately available and accessible for emergencies and consultations.

(11) Sessions

Currently, PR is conducted with a widely varying number of sessions. We are unaware of any data that specifies an exact number of sessions that should be included in a PR program. However, published professional guidelines generally recommend ranges, typically 2 or 3 sessions per week over a period of 12 to 18 weeks for maximum physiological benefits. This equates to a range of approximately 24 to 54 sessions in total; the mean is 39 sessions. Since the primary goal of PR is to facilitate and encourage independent exercise at home, we believe coverage of 36 sessions in the facility setting is appropriate. Further, the current NCD (20.10) for cardiac rehabilitation allows for initial coverage of up to 36 sessions. Since the goals and objectives of these two programs are similar with respect to the patients' ability to achieve selfmanagement of their diseases, we believe those limits are appropriate here. Therefore, we are proposing to allow up to 36 sessions for services provided in connection with a PR program. Patients should generally receive 2 to 3 sessions per week, which are a minimum of 60 minutes each. We propose to allow no more than one session per day, since these beneficiaries have significant respiratory compromise and would not typically be capable of doing more than one aerobic exercise session. We are especially interested in comments regarding the proposed optimal number of sessions, while acknowledging that each individual has a different degree of

(12) Other Items and Services

The MIPPA allows the inclusion of additional items and services as required elements of a PR program, under certain specific conditions. We are not proposing any additional items and services at the present time. We may consider the addition of other items and services through future rulemaking.

d. Coding

We are proposing to create one HCPCS code to describe and to bill for the services of a PR program as specified

in section 144(a) of the MIPPA, GXX30, Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session per day. This G-code is to be billed when the patient performs physician-prescribed aerobic exercises that are targeted to improve the patient's physical functioning and may also include the other aspects of pulmonary rehabilitation, such as education and training. Because the physician's role in the PR program is defined in a similar manner to that in the cardiac rehabilitation program, we believe that the physician work component should be analogous to that of CPT code 93797, cardiac rehab without telemetry. Therefore we are proposing work RVUs of 0.18 RVUs for this new G-code. Using this same reference code, we are proposing that the malpractice RVUs be 0.01 RVUs.

To establish the PE RVU payment for the proposed new PR G-code, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes, G0237 and G0238, as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798. Given the various individuals, acting under the supervision of a physician, can make up the PR multidisciplinary team, we believe that the clinical labor for the PR G-code can be best represented by the following labor types taken from the PE database: The nurse "blend" (RN/LPN/ MTA), the respiratory therapist (RT), the social worker/psychologist and the medical/technical assistant—which we selected to represent various specialists involved in furnishing this service; these are valued at \$0.37, \$0.42, \$0.45, and \$0.26 per minute, respectively. Using an average of these values, \$0.375 per minute, we are proposing to use the nurse blend labor type found in the cardiac rehabilitation CPT codes, at \$0.37 per minute, as the typical value for the PR clinical labor and assigning 28 minutes of clinical labor time for the new PR G-code based on the various components of the proposed PR program.

For the equipment PE inputs, we reviewed the direct PE inputs for similar existing codes and are proposing a pulse oximeter (with printer), a 1-channel ECG, and a treadmill. Since no typical supplies were listed for similar existing codes in the PE database, we have not proposed any specific supplies for this proposed new G-code.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services

Section 152(b) of the MIPPA provides for coverage of kidney disease education (KDE) services for patients. The following is an outline of our proposals to implement the statutory amendments.

a. Background

The kidneys have several life-sustaining functions. Waste and excess fluid is removed by the kidney through filtration and the concentration of salt and minerals in the blood is maintained. Additionally, the kidneys help regulate blood pressure, are involved in the process of red blood cell production, and are needed for bone health. When kidneys are damaged, these functions are impaired.

Kidney damage can occur for a variety of reasons and may develop quickly (acute renal failure) or slowly. By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones.

When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (that is, dialysis) or a kidney transplant to maintain life. There are tests to help detect kidney disease. Currently, the most important measurement of kidney function is called glomerular filtration rate (GFR) and is a measure of how quickly blood is filtered through the kidney's filter, which is called the glomeruli.

Patients can be classified into 5 stages based on their GFR, with Stage 1 having kidney damage with normal or increased GFR to stage 5 with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

While predicting the timing of progression from stage IV CKD to kidney failure is difficult due to the lack of data, anticipatory objective information for the stage IV CKD patient is critical for management of comorbidities, prevention of uremic complications, and informed decision-making about renal replacement options and their respective benefits and risks. Collins notes from United States Renal Data System (USRDS) data from 2007 that "despite the large number of patients with varying stages of CKD, only approximately 100,000 reach end-stage renal disease (ESRD) annually in the

United States." ⁶ CKD primarily affects the elderly and commonly coexists with other chronic diseases including hypertension, diabetes, and cardiovascular disease. Consequently, the risk of mortality and morbidity are increased substantially with advancing CKD stages.

Individuals with CKD may benefit from educational interventions due to the large amount of medical information that could affect patient outcomes including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. There is evidence that many pre-dialysis patients lack knowledge about their condition and may develop a sense of despair regarding their condition. Predialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

b. Statutory Authority

Section 152(b) of the MIPPA amended section 1861(s)(2) of the Act by adding a new subparagraph (EE) "kidney disease education services" as a Medicare-covered benefit under Part B. This new benefit is available for Medicare beneficiaries diagnosed with Stage IV CKD, who in accordance with accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. KDE services will be designed to provide comprehensive information regarding:

• The management of comorbidities, including delaying the need for dialysis;

• Prevention of uremic

complications:

• Options for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and incenter, as well as vascular access options and transplantation);

• Ensuring that the beneficiary has the opportunity to actively participate in his or her choice of therapy; and

• Tailored to meet the needs of the beneficiary involved.

c. Public Meetings

Section 1861(ggg)(3), as added by section 152(b) of the MIPPA, requires that the Secretary set standards for the content of the KDE services after consulting with various stakeholders, who to the extent possible, had not

received industry funding from a drug or biological manufacturer or dialysis facility. On November 6, 2008, and December 16, 2008, we held two feedback sessions to solicit stakeholder comments regarding the implementation of section 152(b) of the MIPPA. Both feedback sessions were open to the public. In addition to the feedback sessions, we conducted an internal review of the available medical evidence, literature, and currently available CKD patient education programs. Transcripts from both events are available on the CMS Web site at http://www.cms.hhs.gov/ CoverageGenInfo/ 08 CKD.asp#TopOfPage.

(1) The November 6, 2008 Feedback Session

The first feedback session was conducted as a Special Open Door Forum (ODF) at the CMS Headquarters on November 6, 2008. Approximately 200 people, representing approximately 70 organizations, participated via teleconference.

The majority of stakeholders cited the National Kidney Foundation Disease Outcomes Quality Initiative (NKF KDOQI) guidelines that define Stage IV CKD as a GFR measurement of 15-29 ml/min/1.73m2, for purposes of classification and evaluation of CKD. Stakeholders recommended a variety of modalities for providing education services. One-on-one sessions between the educator and the patient were recommended to facilitate comprehension of the information. Stakeholders indicated that diagnoses of CKD can be devastating for some patients and patient outbursts, crying, and other disruptions can derail the educational process for large groups. Since all patients do not have the same learning styles or need for information, one stakeholder recommended that each individual be assessed by the treating physician or nonphysician practitioner (NPP) under the supervision of the treating physician for their learning needs and style preferences before or upon referral for KDE services.

Some stakeholders suggested that group education sessions would be appropriate and beneficial for patients, but did not comment specifically on the applicability to the Medicare population. Stakeholders reported that within existing programs, patients were going through a shared experience and group sessions helped facilitate discussion. Other stakeholders recommended that initial education sessions be performed in a group setting, with one-on-one follow-up sessions. We received recommendations

⁶Collins AJ, et al. "Who Should be Targeted for CKD Screening? Impact of Diabetes, Hypertension, and Cardiovascular Disease." American Journal of Kidney Diseases, Vol 53, No 3, Suppl 3 (March), 2009: pg. S71.

regarding session length from 15 minutes to 2 hours, or as long as deemed necessary by the educator or the patient.

Some stakeholders recommended against using the Web or telemedicine since these modalities may not be appropriate or facilitate effective comprehension of material in older adults. Other stakeholders indicated that we needed to keep in mind that a patient's uremia may impair comprehension of the materials, that these patients are sick, and that the elderly often need to have information provided in a simplistic, repetitive manner.

Regarding the clinically appropriate topics and content standards for KDE services, various stakeholders indicated that the following information should be included in the curriculum:

- Basic overview of kidney functions and CKD pathophysiology.
- Survival rates based on choice of treatment or if the patient declines treatment
- Quality of life and psychosocial adjustments.
- Structured, unbiased, uniform information about all renal replacement modalities, with no appropriateness assumptions presented by the educator.
 - The right to decline treatment.
 - Evidence-based content.
- Prolonging remaining kidney function.
- Patient participation in management of kidney disease.
 - Sexuality and fertility issues.
 - Transplant options.
 - Smoking cessation.
 - Medication compliance.
- Financial support and insurance coverage.
 - Diet and exercise.
 - Vocational rehabilitation.
- Treatment and management of comorbidities.
- (2) The December 16, 2008 Feedback Session

On December 16, 2008, the second feedback session was hosted at the Agency for Healthcare Research and Quality (AHRQ). Approximately 60 people representing approximately 40 organizations participated. In preparing for this meeting, we researched and developed a list of approximately 30 experts and educators that are currently providing kidney disease education to individuals or treating patients with CKD, only 10 of which were able to participate. To accommodate those stakeholders that were unable to attend the AHRQ stakeholders meeting, we accepted additional feedback at the following e-mail address: CKDEducation@cms.hhs.gov.

We asked each meeting attendee to fill out a disclosure statement that described any industry funding he or she had received from a drug/biological manufacturer or dialysis facilities, since the MIPPA requested that we consult with various stakeholders, to the extent possible, that had not received such industry funding. The majority of the meeting participants or the organizations represented had received industry funding with few exceptions.

When asked about the accepted clinical criteria for classifying someone with Stage IV CKD, most stakeholders stated that Stage IV CKD is best defined as an individual with an estimated GFR of between 15 and 29 or 30 ml/min/ 1.73m2. One stakeholder suggested that to decrease variability between creatinine methodologies, they recommended using a laboratory that traces its serum creatinine technique to IDMS (Isotope dilution mass spectrometry reference measurement procedure). This stakeholder also indicated that the MDRD (modification of diet in renal disease) study equation has been slightly modified to account for labs that are traceable to IDMS.

We asked the stakeholders to report on the different modalities of education that would be appropriate for kidney disease patient education. One stakeholder indicated that considerations need to be made regarding the educational needs of different communities and cultures. Several stakeholders indicated that faceto-face or group sessions are the preferred modalities for providing education services. One stakeholder indicated that groups larger than 20 may make it harder for all participants to ask questions. Stakeholders recommended that we allow flexibility to balance the needs of individual CKD patients that have varying degrees of need for information and education. Several stakeholders indicated that curriculum content should include information regarding all renal replacement therapy options (including no treatment), vascular access options, available support services, and management of co-morbidities including diabetes, blood pressure management, bone disease, and mineral metabolism.

Stakeholders recommended numerous frequency and duration combinations. One stakeholder recommended a variety of combinations of six 1-hour classroom group sessions including one session per week (over a 6-week period); six sessions over a weekend (3 sessions on Saturday; 3 sessions on Sunday); or all 6 sessions on 1 day during a weekend. This stakeholder also recommended that sessions should be standardized so that

an individual can take sessions when they are offered to meet their scheduling needs. Stakeholders recommended sessions that lasted between 15 minutes and 2.5 hours. One stakeholder indicated that pre- and post-assessments should be included as part of the education programs.

When asked what factors in existing education programs have led to the best patient outcomes, we received a variety of responses such as varying the training format, providing information repetitively, and presenting information at the appropriate reading level for the audience. Stakeholders recommended that all aspects of the education services be provided in an objective and neutral manner, not skewing the information toward one or more renal replacement therapy modalities.

d. Implementation

Consistent with section 1861(ggg) of the Act, we are proposing to amend 42 CFR part 410 to add new § 410.48 for KDE services as a Medicare Part B benefit.

(1) Definitions (proposed § 410.48(a))

As related to the implementation of section 1861(ggg) of the Act, we are proposing the following definitions in § 410.48:

 Kidney Disease Patient Education Services: Consistent with section 1861(ggg)(1) of the Act, we are proposing to define Kidney Disease Patient Education Services as face-toface educational services provided to patients with Stage IV CKD. We are proposing that the services be provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-toface education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy, and that the services be designed to be tailored to meet the needs of the beneficiary involved.

Some stakeholders recommended that sessions be conducted face-to-face due to varying patient literacy levels. Other stakeholders recommended against using Web-based education resources since the elderly may not be as comfortable with or lack access to the Internet. In light of these considerations, we believe that face-to-face education services are the most appropriate means for providing these services.

• Physician: For purposes of KDE services, a physician will be defined using the definition in section 1861(r)(1)

of the Act; it defines "physician" as "a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) [of the Act]."

 Qualified Person: Consistent with section 1861(ggg)(2)(A) of the Act, for purposes of KDE services, we are proposing to define a "qualified person" as a physician (as defined in section 1861(r)(1) of the Act); a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act, and implemented in § 410.74, § 410.75, and § 410.76 of this subpart). A provider of services located in a rural area is also included in the statute's definition of a qualified person. Section 1861(u) of the Act defines "provider of services" to be "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of sections 1814(g) and section 1835(e) [of the Act], a fund". We are proposing to define a "qualified person" to include a provider of services located in a rural area and would include each of these healthcare entities except for a "fund."

We do not believe that it would be appropriate to recognize a fund described by sections 1814(g) and 1835(e) of the Act as a "qualified person". These funds are defined as providers of services only for the limited purpose of paying for the services of faculty physicians when they furnish certain services under the authority of sections 1814(g) and 1835(e) of the Act. These funds are not licensed as hospitals; they do not bill Medicare and do not receive payment. Moreover, these funds do not comply with Medicare conditions of participation and do not have provider agreements with Medicare. Because we do not believe that it would be appropriate to include "funds" in the definition of a "qualified person" for purposes of the KDE benefit, we are proposing to exclude funds described by sections 1814(g) and section 1835(e) of the Act from our definition of a provider of services located in a rural area as defined in section 1886(d)(2)(D) of the

In order for a provider of services to be a "qualified person," the entity must be located in a rural area. We are proposing to include in the definition of a "qualified person", only those hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation

facilities (CORFs), home health agencies (HHAs), and hospice programs that are located in a rural area under section 1886(d)(2)(D) of the Act (as defined in our regulations at § 412.64(b)(ii)(C)) and to include hospitals and CAHs that are reclassified from urban to rural status pursuant to section 1886(d)(8)(E) of the Act, as defined in § 412.103. Specifically, § 412.64(b)(ii)(C) defines "rural" to mean any area outside an urban area, which § 412.64(b)(ii)(A) defines as a metropolitan statistical area (MSA) as defined by the President's Office of Management and Budget (OMB). Therefore, we believe that a hospital, CAH, SNF, CORF, HHA, or hospice program that is not physically located in an MSA should be considered "rural" for this benefit.

Section 1886(d)(8)(E) of the Act, implemented in § 412.103, requires us to treat hospitals that meet specified criteria as geographically rural under section 1886(d)(2)(D) of the Act even though they are physically located in an MSA. Because the statute identifies these hospitals as rural, we believe that it is appropriate to consider these hospitals a qualified person for purposes of the KDE benefit. The Conditions of Participation for CAHs in § 485.610 also include a provision to allow a hospital located in an urban area to reclassify as rural for purposes of becoming a CAH through section 1886(d)(8)(E) of the Act, as defined in § 412.103. Because a hospital or CAH specified under section 1886(d)(8)(E) of the Act is treated as being located in a rural area under section 1886(d)(2)(D) of the Act, we are proposing to recognize those hospitals or CAHs as a "qualified person" for purposes of the KDE benefit.

- Renal Dialysis Facility: The Congress has provided in section 1861(ggg)(2)(B) of the Act that a "renal dialysis facility" may not be a "qualified person." We are defining this term, consistent with § 405.2102 of this title, as "a unit which is approved to furnish dialysis service(s) directly to ESRD patients."
- Stage IV Chronic Kidney Disease:
 Section 1861(ggg)(1)(A) of the Act states that KDE services shall be furnished to beneficiaries diagnosed with Stage IV CKD, who according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. Based on stakeholder feedback, we are proposing to define Stage IV CKD as kidney damage with a severe decrease in GFR quantitatively defined by a GFR value of 15–29 ml/min/1.73 m², using the Modification of Diet in Renal Disease (MDRD) Study

formula. Because there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, we are proposing to cover all stage IV patients.

During both the November 6, 2008, and the December 16, 2008 feedback sessions, the majority of stakeholders indicated that Stage IV CKD is currently determined as kidney damage with a severe decrease in the estimated GFR value (15 to 29 mL/min/1.73 m²). While there appeared to be agreement among the stakeholders regarding the estimated GFR values for the diagnosis of Stage IV CKD, some stakeholders indicated that only using the estimated GFR value to determine the severity of a beneficiary's CKD may be insufficient. To decrease variability between creatinine methodologies, stakeholders recommended using a laboratory that traces its serum creatinine technique to IDMS and that the MDRD study equation has been slightly modified to account for labs that are traceable to IDMS.

(2) Covered Beneficiaries (Proposed § 410.48(b))

Consistent with section 1861(ggg)(1)(A) of the Act, we are proposing that KDE services be furnished to beneficiaries with Stage IV CKD based on the definition of Stage IV CKD defined in proposed § 410.48(a), and have been referred for such services by the physician managing the beneficiary's kidney condition.

(3) Standards for Qualified Persons and Exclusions (Proposed § 410.48(c))

We are proposing to require that a qualified person be able to properly receive Medicare payment under 42 CFR part 424 (Conditions for Medicare Payment). In § 410.48(c), we are proposing to establish exclusions from the term "qualified person." Consistent with section 1861(ggg)(2)(B) of the Act, we specifically exclude a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located outside of a rural area under § 412.64(b)(ii)(C), except for a hospital or CAH that is treated as being located in a rural area under § 412.103. In addition, consistent with section 1861(ggg)(2)(B) of the Act, a renal dialysis facility is not a qualified person.

While we are not proposing specific education, experience, training, and/or certification requirements at this time,

⁷Levey, A.S., Greene, T., Kusek, J., and Beck, G.A. J Am Soc Nephrol. 2000. 11: p. 155A.; Levey, A.S., Bosch, J.P., Lewis, J.B., Greene, T., Rogers, N., and Roth, D. Ann Intern Med. 1999 Mar 16; 130(6):461–70.

we are specifically seeking public comments on the appropriate level of education, experience, training, and/or certification appropriate for a qualified person to effectively provide KDE services and may provide such provisions in the final issuance of this rule or in future rulemaking. Factors to consider include specific education and expertise regarding the topic and ability to explain these areas for the purpose of patient education:

- General kidney physiology and test results that would be associated with CKD.
- Psychological impact of the disease on the beneficiary, and impact on family, social life, work, and finances.
- The management of comorbidities (such as cardiovascular disease, diabetes, hypertension, anemia, bone disease, and impairments in functioning) common in persons diagnosed with CKD.
- Renal replacement therapeutic options, treatment modalities and settings, and advantages and disadvantages of each treatment option.
- Diet, fluid restrictions, and medication usage to include side effects and informed decisionmaking.
- Encouragement of patient active participation in decisionmaking and the ability to tailor educational needs to the individual beneficiary.
- Other areas of health deemed important to patients with CKD.
- (4) Standards for Content of Kidney Disease Patient Education Services (Proposed § 410.48(d))

We believe that patient education needs vary by severity of the disease, the age of the patient, the patient's comorbid conditions and disabilities, the patient's primary language and culture, and desire to learn more about the disease and treatment options. Education services are more effective if the services are tailored to meet an individual beneficiary's needs. We are proposing that KDE services include the content as specified in proposed § 410.48(d). According to an article by Paula Ormandy 8 in the Journal of Renal Care, patients are most interested in receiving information on the following topics, which was echoed by many stakeholders during the feedback sessions.

- Basic information regarding CKD, how the kidneys work, what happens when the kidneys fail, and the permanence of the disease.
- Survival rates with and without renal replacement therapy and survival

- rates if the patient refused treatment for their CKD.
- The need for kidney transplantation.
- Ûnbiased information about renal replacement therapy (RRT) options including advantages and disadvantages for all modalities.
- Adequate information regarding why some RRT options were not viable for a patient.
- How different RRT options affected the patient's co-morbid conditions.
- Effect of RRT choices on lifestyle, such as treatment flexibility and treatment session length.
- Whether a patient will need assistance based on RRT modality choice and training requirements for helpers.
 - The right to refuse treatment.
- Effects of the disease, and the subsequent treatment, on the patient's physical appearance.
- Patient recognition of the symptoms that would empower the patient with the knowledge to seek help.
- Disease and treatment complications related to renal replacement therapy such as hypertension, catheter migration, temporary/permanent loss of dialysis access, and risk of infection at the access sight.
- How to control and manage consequences of complications and symptoms (for example: treatment for itchy skin or insomnia).
- The ability to travel and organize holidays depending on RRT choice.
- Maintenance of social relationships, activities, and commitments.
- How the disease and RRT may affect the patient's ability to continue working.
 - Available support services.
- Medication management, including side effects and risks related to non-compliance to prescribed medication regimen.
- (5) Session Specifications (Proposed § 410.48(e))
- (a) Limitations on the number of sessions: Consistent with section 1861(ggg)(4) of the Act, we will limit the number of KDE sessions to six (6).
- (b) Session Length: In the absence of supporting evidence for session length, we are proposing to define the session length as 60 minutes which coincides with the session length of some programs in existence and is the approximate average of stakeholder suggested session lengths.

(c) Individual and Group Session Format: Consistent with section 1861(ggg)(C)(iii) of the Act, we are proposing that the qualified person

tailor the design of the education services to meet the needs of the beneficiary based on whether the beneficiary needs more individualized education, would benefit more from a group environment, or a combination; and consider any communication accessibility needs based on disability, language and health literacy.

During the feedback sessions, we received a variety of recommendations regarding how education services should be provided, including a combination of group sessions, one-onone sessions, and multi-media presentations. Stakeholders recommended that one-on-one sessions, between the beneficiary and the educator, facilitated quicker comprehension of the education materials than group sessions, and provided the best opportunity to tailor the sessions to meet the patient's needs. Other stakeholders indicated that group sessions provide patients with the benefit of responses to questions posed by different group participants.

Medical services, generally speaking, are provided to beneficiaries on an individual basis. Beneficiaries can also benefit from the interaction in a group setting. We believe that the beneficiary, in consultation with the referring physician, will be able to best determine the education services modality that most effectively meets his or her needs.

(6) Outcomes Assessment

The intent of the education services is for the beneficiary to take the information he or she has learned during the educational sessions in order to facilitate active participation by the beneficiary in the healthcare decisionmaking process with the physician managing his or her kidney condition. We believe that it is important that beneficiaries be assessed at the conclusion of the education sessions and are proposing that program assessments be used by the educators and CMS to assess the effectiveness of the education services, to help improve the programs for future participants, and better facilitate patient understanding of the material.

During the AHRQ stakeholders meeting, various stakeholders indicated that it was important to monitor the effectiveness of the education services to improve the content and delivery of KDE services. Assessing the effectiveness of the KDE services through assessments can be an effective way of measuring how beneficiary needs are being met. Some existing education programs have pre- and posteducation session assessments and are usually administered immediately

⁸ Ormandy, P., "Information Topics Important to Chronic Kidney Disease Patients: A Systematic Review." *Journal of Renal Care* 34(1), 19–27, 2008.

following the conclusion of the education sessions.

We are proposing, based on stakeholder feedback and our general rulemaking authority, that qualified persons develop outcomes assessments and that each beneficiary be assessed during one of the education sessions. We are proposing that the outcomes assessment measure beneficiary knowledge about CKD and its treatment for the purpose, and as a contributor to, the beneficiary's ability to make informed decisions regarding their healthcare and treatment options.

According to an article by Gerald Devins in the Journal of Clinical Epidemiology, an outcomes assessment or test should be able to "measure the adaptive value of ESRD-related knowledge as a contributor to psychosocial and physical well-being, * * * reliably and validly assess patient knowledge about ESRD and its treatment," * * * "be easy to administer and score," and * * * "require only basic reading skills." 9

After completing the KDE services, the beneficiary should be able to take the information learned and use it to make informed choices about their healthcare during future consultations with the physician managing the beneficiary's kidney condition. It is important that the assessments be tailored to the beneficiary's reading level and language if the assessment is not administered by the qualified person that provided the education services, and be made available to CMS in a summarized format upon request.

We are specifically seeking public comments regarding the development and administration of the outcomes assessments. Factors to consider include:

- Specific topics that should be included as part of the assessment;
- Whether standardization of the outcomes assessment is feasible and/or should be considered;
- The applicability of any standardized assessments that may currently be in existence;
- The feasibility of providing both pre- and post-education assessments;
- Methods for collecting assessments and disseminating best practices for KDE services.
- e. Payment for KDE Services

Section 152(b) of the MIPPA creates a new benefit category for KDE services.

The MIPPA amends section 1848(j)(3) of the Act, which allows for payment of KDE services under the PFS. KDE services are covered when they are furnished by a qualified person as defined in proposed § 410.48(a) and that meets the requirements of proposed § 410.48(c). We note that there is a possibility that a beneficiary may receive services from more than one "qualified person"; however, payment should be made to only one qualified person on the same day for the same beneficiary.

The "incident to" requirements for physician services at section 1861(s)(2)(A) of the Act do not apply to KDE services because the MIPPA requirements are explicit, in that the education services must be provided by a qualified person, which is defined as a physician, nurse practitioner, clinical nurse specialist or physician assistant, and also includes a provider of services located in a rural area. In the past, we have taken the position that the "incident to" provision does not apply to the implementation of a new service with a distinct benefit category under the PFS. Therefore, the "incident to" requirements will not apply to KDE services.

Rural health clinics (RHCs) do not meet the statutory definition of a provider of services (as defined in 1861(u) of the Act) and cannot be separately paid for furnishing KDE services.

Section 1861(ggg)(4) of the Act limits the number of KDE services that a beneficiary may receive to six sessions. We are proposing to create two HCPCS codes, GXX26 (individual) and GXX27 (group), to describe and to bill for KDE services. The two G-codes consist of 1hour face-to-face KDE services for an individual or group. We are proposing to pay both GXX26 and GXX27 at the nonfacility rate. We are also proposing that GXX26 educational services related to the care of chronic kidney disease; individual per session will be crosswalked to CPT code 97802; and that GXX27, educational services related to the care of chronic kidney disease; group, per session will be crosswalked to CPT code 97804. The rationale for the proposed pricing of the G-codes is based on the similarity of this service to medical nutrition therapy in the individual (97802) and group (97804)

In the CY 2010 OPPS/ASC proposed rule, we discuss our proposed payment for KDE to qualified persons who are hospitals, CAHs, SNFs, CORFs, HHAs, or hospices. Commenters should submit specific comments on our payment proposal for this benefit, including the

method and amount of payment, for qualified hospitals, CAHs, SNFs, CORFs, HHAs, or hospices in response to the CY 2010 OPPS/ASC proposed rule. We will discuss our final payment policy for these qualified providers in the CY 2010 OPPS/ASC Final Rule.

f. Effective Date

Medicare Part B coverage of outpatient kidney disease patient education services will be effective for services furnished on or after January 1, 2010.

11. Section 153: Renal Dialysis Provisions

Section 153 of the MIPPA requires changes to ESRD facilities for ESRD services effective January 1, 2010. The following is a summary of these changes.

Section 153(a)(1) of the MIPPA increases the current ESRD composite rate by 1.0 percent for services furnished on or after January 1, 2010. This also requires us to update the adjusted drug add-on. Since we compute the drug add-on adjustment as a percentage of the composite rate, the drug add-on percentage is decreased to account for the higher CY 2010 composite payment rate and results in a 15.0 percent drug add-on adjustment for CY 2010. As a result, the drug add-on amount of \$20.33 per treatment remains the same for CY 2010, which results in a 15.0 percent increase to the base composite payment rate of \$135.15. (See section II.I.6. of this proposed rule for further discussion.)

The composite rate paid to hospital-based facilities will be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2010. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

These MIPPA provisions are selfimplementing and require no substantive exercise of discretion on the part of the Secretary. A detailed discussion of the MIPPA provisions can be found in section III. of the CY 2009 PFS final rule with comment period (73 FR 69881).

⁹ Devins, G., et al. "The Kidney Disease Questionnaire: A Test for Measuring Patient Knowledge about End-Stage Renal Disease." *J Clin Epidemiol*. Vol. 43, No. 3. pp. 297–307, 1990.

12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

a. Background

(1) Process for Revising the List of Statutorily Named Compendia

Generally, compendia are "pharmacopeia providing information on drugs, their effectiveness, safety, toxicity, and dosing—are frequently used to determine whether a medication has a role in the treatment of a particular disease; these roles include both therapeutic uses approved by the U.S. Food and Drug Administration (FDA) and off-label indications" (Agency of Healthcare Research and Quality (AHRQ), Potential Conflict of Interest in the Production of Drug Compendia White Paper). 10 Compendia are published by various institutions and by traditional reference book publishing houses.

Section 1861(t)(2)(B)(ii)(I) of the Act lists the following compendia as authoritative sources for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen: American Medical Association Drug Evaluations (AMA–DE); United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and American Hospital Formulary Service-Drug Information (AHFS–DI). Due to changes in the pharmaceutical reference industry, AHFS-DI is the only statutorily-named compendium that is

In addition to these compendia, the statute provides an alternative method for identifying medically-accepted offlabel uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors may use supportive clinical evidence in peerreviewed medical literature" to make such determinations. Thus these medically-accepted uses could be identified even if there were no compendia recognized for this purpose. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

currently in publication.

Section 1861(t)(2)(B) of the Act provides the Secretary the authority to

revise the list of compendia in section 1861(t)(2)(B)(ii)(I) for determining medically-accepted indications for offlabel use of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Consequently, in § 414.930, we established an annual process to revise the list and establish a definition of "compendium" in the CY 2008 PFS final rule with comment period (72 FR 66222, 66303 through 66306, and 66404).

On March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee or MEDCAC (formerly the Medicare Coverage Advisory Committee (MCAC)) met in public session to advise CMS on the appropriate criteria for the recognition of compendia for the identification of medically-accepted indications of drugs and biologicals used in an anti-cancer therapy, and the degree to which the then listed and other available compendia displayed those criteria. The evidence the MEDCAC considered to derive its recommendations included a presentation of the technology assessment (TA) performed for AHRQ by staff of the Tufts-New England Medical Center (Tufts-NEMC) and Duke **Evidence-based Practices Centers** (EPCs), scheduled stakeholder presentations, as well as testimony from members of the public. As is customary, the MEDCAC panelists elicited additional information from the presenters and discussed the evidence in preparation for a formal vote. The MEDCAC recommended that the following criteria, referred to as "desirable characteristics," should be used to recognize compendia for identification of medically-accepted indications of drugs and biologicals in anti-cancer therapy:

- Extensive breadth of listings.
- Quick processing from application for inclusion to listing.
- Detailed description of the evidence reviewed for every individual listing.
- Use of pre-specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit "Not recommended" listing when validated evidence is appropriate.
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies.
- Explicit "Equivocal" listing when validated evidence is equivocal.
- Process for public identification and notification of potential conflicts of interests of the compendia's parent and sibling organizations, reviewers, and

committee members, with an established procedure to manage recognized conflicts.

We incorporated the MEDCAC recommended desirable characteristics into the compendia review process. All information on this MEDCAC meeting can be found on the CMS Web site at http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=33.

Although we did not rank these ten MEDCAC desirable characteristics, the MEDCAC desirable characteristics that addressed transparency and conflict of interest of compendia were considered to be of high priority (72 FR 66304 through 66305). In addition, we considered the need to enhance transparency in the compendia review process to preserve the integrity of the review process (72 FR 66222, 66303 through 66306, and 66404).

During the 2008 compendium review cycle, we considered requests regarding the following five compendia: The AMA–DE Compendium; National Comprehensive Cancer Network Drugs and Biologics (NCCN) Compendium; Thomson Micromedex DrugDex Compendium; Thomson Micromedex DrugPoints Compendium; and Clinical Pharmacology Compendium. Our decisions are posted on the CMS Web site at http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage. In

02_compendia.asp#TopOfPage. In summary, we issued the following decisions regarding those compendia requests:

- NCCN was added to the list of compendia.
- Thomson Micromedex DrugDex was added to the list of compendia.
- Clinical Pharmacology was added to the list of compendia.
- Thomson Micromedex DrugPoints was not added to the list of compendia.
- AMA–DE was removed from the list of compendia.

(2) MIPPA Requirement for Compendia

Section 182(b) of the MIPPA amended section 1861(t)(2)(B) of the Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests." There is a growing body of literature, including that from the Institute of Medicine (IOM), 11 that discusses the conflict of interest between research funding and

¹⁰ Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64.

¹¹Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Available online at http://www.nap.edu/ catalog.php?record_id=12598.

research results. Some authors have stated that there is a conflict of interest if an entity has a financial, legal, or political interest that is counterproductive to the performance of their legal or ethical responsibilities. 12 Although this widely discussed correlation depicts a classic representation of a financial conflict of interest, we believe nonfinancial conflicts of interests also deserve attention. Nonfinancial conflicts of interests have the potential to interfere with honest reporting, transparency and fair review of applications submitted to compendia publishers.¹³ Therefore, in light of such concerns, the existence of financial and nonfinancial conflicts of interests would threaten the impartiality of the recommendations made in the compendia. We believe that section 182(b) of the MIPPA, "Revision of definition of medically-accepted indication for drugs * * * Conflict of Interest" is designed, in part, to address this issue in the compendia review

(3) Proposed Revisions of Compendia Standards

We believe that the implementation of this statutory provision that compendia have a "publicly transparent process for evaluating therapies and for identifying potential conflicts of interests" is best accomplished by amending the current definition of a compendium at § 414.930(a) to include the MIPPA requirements and by defining the key components of publicly transparent processes for evaluating therapies and for identifying potential conflicts of interests. In order to implement the MIPPA requirements concerning a publicly transparent process for evaluating therapies, we propose that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site. This mode of publication provides broad contemporaneous public access to relevant materials. We believe that public access to such materials will increase transparency of the process used by compendia publishers for evaluating therapies and facilitate independent review of recommendations by interested parties. In addition, as discussed in the CY 2008 PFS final rule with comment period (72) FR 66305 through 66306), such

disclosure may assist beneficiaries and their physicians in choosing among treatment options.

As expressed in the February 14, 2008 letter from the U.S. Senate Committee on Finance to the CMS Acting Administrator Kerry Weems, "conflicts of interest have been proven in peerreviewed studies to have a significant impact on scientific outcomes and medical care." 14 Since compendia recommendations are generally dependent on evidence from peerreviewed studies, we believe that conflicts of interests may arise from relationships between individuals who substantively participate, such as individuals who contribute more than a clerical role, in the development of compendia recommendations and the applicants (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium) for the inclusion of drug or biological recommendations in compendia. These relationships may involve, for example, publishers of compendia and peer-reviewed journals, their editorial or advisory boards, drug manufacturers, physicians or providers that derive income from the prescribing or administration of drugs, researchers that have a personal or academic interest in the drug study, or others who may provide incentives to influence the prescribing behaviors of physicians. 15 As illustrated in the AHRQ Potential Conflict of Interest in the Production of Drug Compendia White Paper, these potential financial and nonfinancial conflicts exist at the various stages of the evaluation process. The White Paper also describes compendia publication users (for example, the public, physicians, other caregivers, and public/ private insurers) and the objectives of each user when referencing the compendia. Therefore, these potential financial and nonfinancial conflicts may be problematic for users of the compendia to rely on the validity of the compendia recommendations.16

Section 182(b) of the MIPPA requires a publicly transparent process for: (1) Evaluating therapies, and (2) identifying potential conflicts of interests. In light

of these provisions, we are proposing regulatory safeguards to require that the publicly transparent process for evaluating therapies and identifying potential conflicts of interests include disclosure of certain relevant information. All currently listed compendia will be required to comply with these provisions, as of January 1, 2010, to remain on the list of recognized compendia. We view compendia publishers as generally responsible for the integrity of their publications. Therefore, we urge currently listed compendia publishers to submit evidence demonstrating compliance with the MIPPA provisions that "no compendia may be included on the list of compendia" unless the compendium has a publicly transparent process for therapy evaluation and conflict of interest identification to CMS no later than December 31, 2009. In addition, any compendium that is the subject of a future request for inclusion on the list of recognized compendia will be required to comply with these provisions. We believe that the statute is clear that no compendium can be on the list if it does not fully meet the standard described in section 1861(t)(2)(B) of the Act, as revised by section 182(b) of the MIPPA.

b. Revisions to § 414.930, "Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen"

We are proposing the following amendments to § 414.930(a):

- To revise the definition of "compendium" by adding an additional requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.
- To add the definition of "publicly transparent process" for evaluating therapies. We propose that assurance of a publicly transparent evaluation process is best achieved by establishing a process that provides for public disclosure of the evidence considered and the review of that evidence leading to the development of compendia recommendations.¹⁷ By providing for this disclosure, we hope to ensure validity in the use of compendia for identifying medically-accepted uses of off-label treatments for purposed of section 1861(t)(2)(B) of the Act. Thus, we believe that in the interest of providing a publicly transparent process

¹²Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy, Science & Law.* 7:1–16.

¹³ The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine*. 5(9):1299–1301, Retrieved March 19, 2009 from http://www.plosmedicine.org.

¹⁴ United States Senate Committee on Finance Correspondence. (2008, February 14). CMS Process and Actions Concerning Approval of Anti-Cancer Drug Compendia.

¹⁵ The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine*. 5(9):1299–1301, Retrieved March 19, 2009 from http://www.plosmedicine.org.

¹⁶ Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64&.

¹⁷ Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy*, Science & Law. 7:1–16.

for evaluating therapies and maximizing that transparency, a compendium should publish the complete application for inclusion, exclusion, or deletion of a therapy including criteria used to evaluate the request, on its Web site. We believe that in accordance with that publicly transparent process, a compendium should similarly publish the names of the individuals who have substantively participated in the development of compendia recommendations, along with transcripts of meetings and records of votes. This provides an opportunity for the public to consider the process used by the compendia in evaluating a specific therapy and independently reach conclusions about the adequacy of the application in light of the compendium's final recommendation. We request comments on the requirement for publication of a transcript and the suitability of other alternatives such as minutes or other documents.

 To add a definition regarding a "publicly transparent process for identifying potential conflicts of interests," and clarify the essential elements of such a process. We propose that a publicly transparent process for identifying potential conflicts of interests is best demonstrated by a process that requires public transparency regarding the competing financial and nonfinancial interests that may give rise to such conflicts. Thus, we believe that a compendium should have a process for disclosing by publication on its publicly accessible Web site, certain information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations as well as their immediate family members (as defined in § 411.351). A process for providing disclosure of interests by immediate family members is necessary because such interests could represent potentially competing financial conflicts that could influence the review and individuals responsible for the compendium's recommendations.18

We believe that the process for identifying potential conflicts of interests should include information regarding ownership and investment interests of those individuals who are responsible for the compendium's recommendation. Such information should include the names of those entities with which the individual has an ownership or investment

relationship (similar to those relationships defined in § 411.354), the nature and length of the relationships, other financial relationships that may derive fron either a direct or indirect relationship (similar to thise relationships identified in 42 CFR 411.354, and the significance (for example, dollar value) of those relationships. By requiring a process for identification of such relationships, we are providing a process for the public to have access to information regarding potential conflicts of interests. We believe that information concerning the value of financial relationships is necessary because it would permit the public to assess the degree of influence that a relationship may have over an individual's decisions or judgments.19 We request comments on the suitability of this process or whether the compendia should prescribe its own process. In addition, we request comments specifically addressing whether information regarding immediate family members is necessary for conflict of interest determinations.

We note that the publishers of the four compendia that are currently recognized for this purpose have already adopted conflict of interest disclosure policies that are similar to our proposal. Though there are individual differences among the publishers, we note that these policies commonly include publication on the compendia publisher's Web site of the name of the individuals that participate in the generation of the compendia recommendation and the entity with which there is a relationship, the nature of the relationship (for example, salary, ownership, grant support), and the value of the relationship. Some include this information as it relates to family members of the individual.

Additional information with respect to the conflict of interest policies of those compendia we reviewed during the 2008 review cycle can be found on their Web sites. For the convenience of the reader we have listed below the Web sites where these policies may be found for each of the four currently recognized compendia.

- AHFS Drug Information: http://www.ahfsdruginformation.com/ off label/interest disclosure.aspx.
- Thomson Micromedex DrugDex: http://www.micromedex.com/about_us/editorial/ed_ConflictofInterest.pdf.
- Gold Standard Clinical Pharmacology: http://

www.goldstandard.com/editorial conflict.html.

• The National Comprehensive Cancer Network: http://www.nccn.org/ about/disclosure.asp?p=about.

In general, certain disclosure policies of the compendia provide for public disclosure of individuals involved in the recommendation to ensure against the appearance of potential conflicts of interests. We believe that a publicly transparent process which provides for the identification of potential conflicts of interest protects the interests of the public, as well as those individuals who participate in the compendia process.

Disclosures of conflicts of interests are triggered by the recommendation regarding the use of the drug or biological rather than by the application for the recommendation. Disclosures published in conjunction with compendia recommendation updates should remain publicly viewable for a reasonable period of time. Specifically, we believe that the disclosures remain available for a period of not less than 5 years. It is not uncommon that serious questions about the use of a drug do not arise until the drug has been used for several years. Thus the relevance of information regarding the development of compendia recommendations may not be recognized until several years after the clinical use in question. We believe that a period of 5 years is a reasonable balance between the burden of maintaining this information and the public's interest in timely access to this information. We welcome comments regarding whether or not a period of not less than 5 years is an adequate timeframe for this balance to occur.

We recognize that some individuals may participate substantively in the development of more than one recommendation. For example, an individual might participate in the review of several drugs or biologicals for a single compendia publisher. We recognize that a single relationship may present a significant conflict of interest in some cases but not others. For example, a process for disclosure by the compendium publisher would be required if an individual whose only conflicted relationship arises from significant income related to the use of a particular drug for lung cancer substantively participated in the compendia review of that drug for lung cancer or for a competitor treatment for lung cancer. If that same individual substantively participated in the compendia review of a different drug for a different disease, the compendia publisher might determine that there is no conflict of interest to disclose.

¹⁸ The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine*. 5(9):1299-1301, Retrieved March 19, 2009 from http://www.plosmedicine.org.

¹⁹Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy*, Science & Law. 7:1–16.

In § 414.930(b)(1), we are revising the CMS process for listing compendia for determining medically-accepted uses of drugs and biologicals in anti-cancer treatment to include consideration of a compendium's meeting of the regulatory definitions. We are also proposing to renumber the subparagraphs of § 414.930(b)(1) to accommodate this change.

Current § 414.930(b)(2) gives CMS the authority to generate an internal request to revise the list of compendia at any time.

H. Part B Drug Payment

- 1. Average Sales Price (ASP) Issues
- a. Immunosuppressive Drugs Period of Eligibility

Section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86) added subparagraph (J) to section 1861(s)(2) of the Act to define a benefit category for immunosuppressive drugs furnished to an individual who receives an organ transplant for which Medicare payment is made, for a period not to exceed 1 year after the transplant procedure. Coverage of these drugs under Medicare Part B began January 1, 1987.

Section 13565 of the Omnibus Budget Reconciliation Act of 1993 (Pub L. 103– 66) (OBRA '93) amended section 1861(s)(2)(J) of the Act to specify that the benefit category included immunosuppressive drugs furnished: During 1995, within 18 months after the date of the transplant procedure; during 1996, within 24 months after the date of the transplant procedure; during 1997, within 30 months after the date of the transplant procedure; and during any year after 1997, within 36 months after the date of the transplant procedure. Beginning January 1, 2000, section 227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) (BBRA) extended the benefit period to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expired during the calendar year.

Section 113 of the Medicare,
Medicaid and SCHIP Benefits
Improvement and Protection Act of
2000 (Pub. L. 106–554) (BIPA) revised
section 1861(s)(2)(J) of the Act to
eliminate the time limits for coverage of
prescription drugs used in
immunosuppressive therapy under the
Medicare program. Effective with
immunosuppressive drugs furnished to
an individual who receives an organ
transplant for which Medicare payment
is made on or after December 21, 2000,
there is no longer any time limit for
Medicare benefits. Although the

statutory benefit category no longer includes a time limit, our regulations at § 410.30(b) continue to reflect the time limits that applied previously. Therefore, we are proposing to make conforming changes to § 410.30(b) to remove the references to the time limits that applied under previous iterations of the statute. This technical change will reduce the potential for confusion about the scope of the benefit. We note that this proposal does not substantively affect Medicare coverage or benefits because it merely conforms the regulations text to the current benefit category, as specified in section 1861(s)(2)(J) of the Act. As noted above, under section 113 of the BIPA, immunosuppressive drugs have not been subject to a time limit since December 21, 2000.

b. WAMP/AMP Threshold

Section 1847A(d)(1) of the Act states that "the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate." Section 1847A(d)(2) of the Act states that, "Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

 The widely available market price (WAMP) for these drugs and biologicals (if any); and

• The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals)."

Section 1847A(d)(3)(A) of the Act states that, "The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B))." The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is "the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both." In CY 2006 through CY 2009, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2010, we propose to specify an applicable threshold percentage of 5

percent for the WAMP and the AMP. At present, the OIG is continuing its comparisons of both the WAMP and the AMP. In April 2008, we implemented a change in the weighting methodology for calculating ASP. Information on how recent changes to the calculation of the ASP may affect the comparison of ASP to WAMP or AMP is limited at this time. Since we do not have sufficient data that suggest another level is more appropriate, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2010. Therefore, we are proposing to revise § 414.904(d)(3) to include the CY 2010 date.

As we noted in the CY 2009 PFS final rule with comment period (73 FR 69752), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. We welcome comments on our proposal to continue the applicable threshold at 5 percent for both the WAMP and AMP for CY 2010.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the approximately 180 drugs on the CAP drug list from an approved CAP

vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. The initial implementation of the CAP operated with a single CAP drug category from July 1, 2006 to December 31, 2008.

After the CAP was implemented, section 108 of the MIEA-TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA-TRHCA requires the Secretary to establish (by program instruction or otherwise) a post payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, after the publication of the proposed rule, we announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after December 31, 2008. Physicians who participated in the CAP have transitioned back into the Average Sales Price (ASP) method of acquiring part B drugs for dates of service after December 31, 2008.

After the postponement was announced, we solicited public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We solicited public comments on several issues, including, but not limited to the following: The categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and participating physicians. We also hosted a CAP Open Door Forum

(ODF) on December 3, 2008, where participants had an opportunity to discuss the postponement and suggest changes to the program. We appreciate the comments that we have received.

In the CY 2009 PFS final rule with comment period, we stated that we would review the public comments and consider implementing changes to the CAP before proceeding with another bid solicitation for approved CAP vendor contracts. Based on this information, in this proposed rule, we are addressing items that were not finalized in the CY 2009 PFS final rule with comment period, and making additional proposals for the CAP. Our approach seeks to better define certain aspects of the program based on our experience. We also seek to continue to increase participation by minimizing the administrative burden for physicians and vendors who choose to participate.

a. Frequency of Drug Payment Amount Updates

As described in the July 6, 2005 IFC (70 FR 39070 through 39071) and § 414.906(c), payment amounts for drugs furnished under the CAP are set through a competitive bidding process, and as described in § 414.908(b), bids that exceed a composite bid threshold of 106 percent of the weighted ASP for the drugs in the CAP category are not accepted. The CAP payment amounts that are calculated from successful bids are updated from the time of the bidding period to the payment year. During the 2006 through 2008 CAP contract period, the initial update calculation used the change in the Producer Price Index (PPI) for prescription preparations to account for the time period between the bidding and the period in which the payment amounts were to be in effect, which was the middle of the first year of the three year CAP contract period (70 FR 39074). Finally, as specified in § 414.906(c), CAP payment amounts are updated again during the second and third year of the contract period based on the approved CAP vendor's reported reasonable net acquisition costs (RNAC). The annual updates are limited by payment amounts described in section 1847A of the Act and codified in § 414.906(c).

Section 1847B(c)(7) of the Act gives the Secretary the discretion to establish an appropriate schedule for the approved CAP vendor's disclosure of RNAC information to us, provided that disclosure is not required more frequently than quarterly. In the July 6, 2005 IFC (70 FR 39075 through 39076), we specified that each approved CAP vendor will disclose its RNAC for the drugs covered under the contract

annually during the period of its contract and that we would calculate an annual payment adjustment based on this information. We specified an annual disclosure of RNAC because it imposes the minimal burden on approved CAP vendors. In 2005, some commenters suggested that more frequent updates would be desirable. Additional feedback about the CAP that was obtained after the program's postponement in 2008, as well as comments on previous rules, indicated that potential vendors would like the frequency of price adjustments to increase. Various commenters have suggested a quarterly price adjustment in order to parallel to the ASP process, to better match payment amounts with increases or decreases in drug costs, and to attract vendor interest. We believe that quarterly adjustments would also lower approved CAP vendors' financial risks because CAP payment amounts will be better able to keep up with unanticipated drug cost increases and would benefit the Medicare program by reacting to significant cost decreases more promptly.

Quarterly price updates also will eliminate the PPI-based increase that currently occurs between the time bids are submitted and the first day of CAP claims processing. The application of the PPI-based payment adjustment described in the July 6, 2005 IFC (70 FR 39074) has resulted in situations where the ASP+6 percent payment amount has been exceeded during the first year of the 3-year approved CAP vendor contract. We do not believe that CAP payment amounts should exceed ASP+6 percent. In our discussion of bid ceilings in the July 6, 2005 IFC, we stated that the bid ceiling "ensures that the CAP will be no more costly to the Medicare program than the alternative method of paying for drugs at 106 percent of ASP. This ceiling is thus consistent with the possibility of realizing savings to the Medicare program. It would also serve to maintain a level of parity between the two systems, preventing a situation in which significant payment differentials might skew incentives and choices (70 FR 39070)." For this reason, and to remain consistent with current regulation text at § 414.906, we believe that all payment amounts calculated under the update process should be limited by the weighted payment amount established under section 1847A of the Act. We also believe that this approach will continue to provide for an "appropriate price adjustment" as required under section 1847B(c)(7) of the Act by improving responsiveness to unexpected price

changes, and continuing a prudent limitation on the magnitude of payment amount adjustments.

Our approach for implementing quarterly updates consistent with the ASP+6 percent limit on payment amounts would be based on composite bid price calculations, as described in the July 6, 2005 IFC (70 FR 39072 through 39073). Additional details about the process are described in further detail in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). Briefly stated, the ASP+6 percent limit would be applied by comparing the (weighted) composite update payment amount, calculated from participating approved CAP vendors' reasonable net acquisition cost data, to most recent available weighted ASP prices for the same drugs. If the composite drug update payment amount exceeds the weighted ASP+6 percent payment limit, the composite payment amount for that group of drugs would be reduced to equal the ASP+6 percent limit by applying an equal percent reduction to each drug in the group. By way of example only, if a quarter's composite update payment was calculated as +2.3 percent, based on the median of all participating approved CAP vendors' data, but the calculated weighted ASP+6 percent limit for that group of drugs was +2.1 percent, the payment amounts for all HCPCS codes in the composite group would be increased by 2.1 percent in order to account for reported increases to the vendor's acquisition cost, but not to exceed the ASP+6 percent limit. This means that a 2.1 percent increase would be applied to CAP payment amounts for all HCPCS codes that are in the composite drug list and are being supplied under the CAP by one or more approved CAP vendors. For HCPCS codes that are priced separately, each code available through the CAP will be compared to the most recent ASP+6 percent limit for that code. CAP payment amounts for codes that exceed the ASP+6 percent limit will be reduced to ASP+6 percent. Each "Not Otherwise Classified" (NOC) drug described in § 414.906(f)(2)(iv), would also be updated on an individual (rather than composite) basis.

We are proposing to discontinue annual CAP payment amount updates and to implement quarterly CAP payment amount updates at § 414.906(c). Because of this proposed change, the special quarterly adjustments described at § 414.906(c)(2) (for the introduction of new drugs, expiration of drug patents or availability of generic drugs, material shortages, or withdrawal of a drug from the market)

will no longer be needed, so we propose deleting those provisions from the regulation, and instead adding details about the payment amount update process described in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). A quarterly RNAC reporting and payment adjustment process would begin as soon as we entered into contracts with the approved CAP vendor(s); that is, beginning with the first quarter during which CAP claims are submitted under the contract. Thus, under this proposal, we would also eliminate the PPI-based adjustment for the time period between the time bids are submitted and the time claims processing begins under the contract, because that adjustment would no longer be necessary. We believe using one payment update process will be easier to administer and would minimize the potential for CAP payment amounts to exceed ASP+6 percent for the first contract year. In order to provide sufficient time for the calculation of payment amount updates, we are proposing that approved CAP vendors report quarterly RNAC data for drug purchased for use under the CAP during the previous quarter within 30 days of the close of that quarter. We have made corresponding changes to regulation text at § 414.906(c) and we welcome comments on these proposed changes.

b. Changes to the CAP Drug List

(1) CAP Drug List

In the July 6, 2005 IFC, we responded to comments on our proposed approach for determining the CAP drug categories and how we select the specific drugs in the CAP drug list (70 FR 39026 through 39034). As stated in the CY 2006 PFS final rule with comment period (70 FR 70237), the CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. Our approach incorporated drugs commonly administered by the range of physician specialties that bill for Part B drugs (70 FR 39030) and resulted in a list of about 180 drugs that were available through the CAP during the CY 2006 through CY 2008 contract period. We also developed a number of methods by which an approved CAP vendor's CAP drug list could be changed (see Table 26 at 70 FR 70242).

We believe that our general approach, to provide a wide variety of drugs to a variety of physicians over a large portion of the United States, is on target. Although we believe that the CAP is a means for physicians to minimize their

drug inventory costs, we acknowledge that participation in the CAP cannot completely eliminate the need for participating CAP physicians to maintain at least a minimal drug inventory at the office. Many physicians who participate in Medicare also provide services to non-Medicare patients, and even physicians with a predominantly Medicare patient population may find it useful to keep a small stock of drugs on hand for unforeseen situations, such as emergencies and breakage.

During the CAP postponement, we became aware that both participating CAP physicians and potential vendors supported narrowing the CAP drug list. Both agreed that low cost drugs should be removed from the CAP. Although these items were initially included in the CAP so that an approved CAP vendor would be in a position to supply many of the Part B drugs that an office might administer, CAP physicians and the vendor community have stated that the inclusion of these items in the CAP creates an accounting, tracking, and claims submission burden for some participants. Based on these comments, we believe that low-cost, frequently utilized items, such as corticosteroid injections, could be removed from the list without significant impact on the CAP's utility to participating CAP physicians. Furthermore, it appears that physicians would be more interested in obtaining expensive products, such as biologicals, through the CAP. However, we are also mindful that narrowing the CAP drug list significantly also would decrease an approved CAP vendor's overall purchase volume, and we believe that this could limit the approved CAP vendor's ability to obtain volume-based discounts from the manufacturers or distributors from which it obtains drugs for use in the CAP. Creating a more tailored CAP drug category also could limit physician participation to one or several specialties, and may create a situation where sudden supply interruptions and unexpected changes to distribution channels could affect a greater proportion of drugs in the program than would be the case with a broader CAP drug category.

Nevertheless, we are proposing to create a new CAP drug category for the next round of CAP contracting. Our approach is intended to address comments about the administrative burden of tracking and billing low cost/high volume items while maintaining access to a variety of high cost items. We are proposing to identify the new CAP drug category using the existing CAP drug category as a starting point.

The 2008 drug list was compiled based on Part B drug claims data, the identification of specialties that frequently administer drugs under Part B, and public comment during rulemaking in 2005 (70 FR 39026 through 39033). We believe that using the 2008 CAP drug list as a starting point would maintain prescribing flexibility for a wide range of specialties and would also maintain access to a wide spectrum of drugs that have been utilized under the program previously. Furthermore, we do not believe it is necessary to develop a new approach because the 2008 CAP drug list was based on heavily utilized drugs in Medicare Part B physician practices; we believe that this approach is on target.

We propose to amend our list based on CAP physician participation, claims data, and comments indicating that the list should be narrowed to higher cost items. First, we would "filter" the original CAP drug category (drugs furnished in 2006 through 2009) by the specialties that most frequently prescribe drugs under the CAP, and the highest dollar volume CAP drugs (top 20 percent of allowed charges) compiled from 2008 claims data. This filtered list appears in Table 35, and we are proposing it as the starting point for the updated CAP drug category. A filtering process based on frequency of claims from a subset of physicians who might participate in the CAP cannot fully capture all drugs that may be used by certain specialties. In other words, the filtering steps described above narrow the CAP drug list based on physician specialties and dollar volume and do not necessarily preserve groups of drugs that certain prescribers may utilize, especially the less frequently utilized items in such groups. Therefore, we are also proposing to "fill in" groups of drugs with related items that do not appear on our list. We will consider "filling in" any drug or biological product that is physician-administered, has a reasonably high utilization in the Medicare population, is related to drugs

already in the CAP (for example, because of similar clinical uses), and is otherwise appropriate for inclusion in the program.

For example, we could consider adding a fourth hyaluronan viscosupplement to the drugs in Table 35, expanding the list of antibiotics, or antiemetics, or by adding a list of "new" and unweighted drugs as in 2006 by using simple claims data thresholds (70 FR 70238). The concept of "filling in" drug groups is supported by feedback from former participating CAP physicians who suggested that certain categories of drugs, such as antibiotics, be more fully represented. We are seeking comments on specific drugs that should be added to the draft list in Table 35.

We also are seeking comment on the method to assess whether a particular drug should be "filled in" so that it is included in the new, narrowed CAP drug category. For example, one process that we have considered and would like comment on is adding drugs from the 2009 through 2011 CAP vendor bidding list that did not pass the "filtering" step described above. The 180 item 2009 through 2011 bidding list was used during the approved CAP vendor bidding for the 2009-2011 contract, and includes CMS-approved items added to the original contract's bid list, as well as items approved for addition during the 2006-2008 contract period. (See the Downloads section at http:// www.cms.hhs.gov/CompetitiveAcquis forBios/03a vendorbackground.asp# TopOfPage). This list's weighting is based on claims volume data by HCPCS code units rather than dollar volume and provides a different perspective than a dollar volume sorting. We would add drugs from the 2009-2011 CAP Vendor bid list to the CAP drug category if the drug's weight is in the top 25 percent of the 2009–2011 CAP vendor bidding list, indicating frequent claims submission, and if the drug's clinical uses are similar to a drug on the proposed list in Table 35. This method

would result in the addition of a number of several commonly used antibiotics, two antiemetic) and several chemotherapeutic agents. Potential additions to our draft list identified by this method appear in Table 36.

Although this method helps "fill in" the proposed CAP drug list, this method still does not fully capture less frequently used drugs, or newly approved drugs. We welcome comments on this method and alternative methods of filling this proposed list.

In order to provide additional flexibility for participating CAP physicians and approved CAP vendors, and to allow for participants to further tailor the program to meet their needs, we are also proposing to add § 414.906(f)(2)(v) to allow approved CAP vendors to submit a request to CMS to add drugs (or biologicals) to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through the CAP. The request and approval process would follow the existing regulations at § 414.906(f), and HCPCS code additions that are requested under this process would still be subject to CMS approval. This proposed process adds to the process for adding newly issued HCPCS codes under § 414.906(f)(2)(iii) and newly approved drugs without HCPCS codes (NOC drugs)under § 414.906(f)(2)(iv). It is intended to facilitate more complete access to groups of drugs that may be used by certain specialties, and drugs used to treat certain disease states without having to rely on rigid definitions of classes of drugs that may not apply well to actual clinical practice across a large and diverse geographic area. We believe that this addition to the methods for changing an approved CAP vendor's drug list (see Table 26 in the November 21, 2006 final rule (70 FR 70242)) will add to the flexibility of the program. We welcome comments on our proposal to update the CAP drug list.

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD

Code	Procedure code description
J0129	INJECTION, ABATACEPT, 10 MG
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0585	BOTULINUM TOXIN TYPE A, PER UNIT
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
J0894	INJECTION, DECITABINE, 1MG
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD—Continued

Code	Procedure code description
J1745	INJECTION INFLIXIMAB, 10 MG
J2323	INJECTION, NATALIZUMAB, 1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2357	OMALIZUMAB INJECTION, 5 MG
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG
J2469	PALONOSETRON HCL, 25MCG
J2503	PEGAPTANIB, 0.3MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J2778	INJECTION, RANIBIZUMAB, 0.1 MG
J2794	RISPERIDONE, LONG ACTING, 0.5MG
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG
J3396	INJECTION, VERTEPORFIN, 0.1 MG
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, Per Dose
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J9010	
J9035	BEVACIZUMAB INJECTION, 10MG
J9041	BORTEZOMIB INJECTION, 0.1MG
J9055	CETUXIMAB INJECTION, 10MG
J9170	DOCETAXEL, 20 MG
J9201	GEMCITABINE HCL, 200 MG
J9206	IRINOTECAN, 20 MG
J9263	
J9305	
J9310	RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10 MG

TABLE 36—POTENTIAL ADDITIONS TO THE DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD (THAT IS, TABLE 35)

Code	Procedure code description		
J3370	INJECTION, VANCOMYCIN HCL, 500 MG		
J9264	PACLITAXEL PROTEIN BOUND PARTICLES, 1MG		
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG		
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG		
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG		
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG		
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG		
J9265	PACLITAXEL, 30 MG		
J9190	FLUOROURACIL, 500 MG		
J9045	CARBOPLATIN, 50 MG		
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG		
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS		

2. Removing Drugs From the CAP list

Although there are several methods under the CAP to add drugs to an approved CAP vendor's drug list, the current regulations do not specify a process for removing drugs from an approved CAP vendor's list. Our experience has shown that interruptions in availability can affect an approved CAP vendor's ability to supply CAP drugs during the course of a 3-year contract. For example, during the first contract period, we became aware of long-term and permanent drug unavailability, sometimes at the HCPCS level, due to removal of drugs from the market, or interruption of supply to an approved CAP vendor for reasons beyond the approved CAP vendor's

control, such as changes to drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements.

In order to better respond to sudden, long-term changes in drug supply that are beyond the control of the approved CAP vendor, we are proposing to allow an approved CAP vendor to request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Our proposal is intended to better manage situations where all NDCs from an entire HCPCS code unexpectedly become unavailable to an approved CAP vendor, and we would require the approved CAP vendor (1) to

document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP, (2) to describe the reason for the unavailability and its anticipated duration, and (3) to attest that the unavailability is beyond the approved CAP vendor's control. Approval of the deletion would apply only to the approved CAP vendor or vendors that requested the deletion. Our proposal is not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide itwe believe the payment amount adjustment proposals discussed in sections II.H.2.a. and f. of this proposed rule would address that concern.

Furthermore, our proposal is also not intended to be used for managing short-term unavailability, or unavailability of a finite duration—we believe the existing drug substitution policy described in § 414.906(f) already addresses those concerns. We are proposing to add this process as § 414.906(g) because those regulations currently provide for additions and substitutions to the CAP drug list, and would therefore require a written request to CMS, as well as CMS'

approval.

Participating CAP physicians who are affected by the deletion of a HCPCS code from an approved CAP vendor's drug list would have the option of remaining with their selected approved CAP vendor and using the ASP (buy and bill) methodology for obtaining the drug that has been deleted, or selecting another approved CAP vendor under the exigent circumstances provision at § 414.908(a)(2). We believe that the deletion of an expensive and highly utilized CAP drug by one approved CAP vendor in the middle of a physician election period could cause hardship for a practice if it had to revert to the ASP methodology of acquiring and billing for that drug. Such a situation would constitute an exigent circumstance. Given CAP's goal of improving access to drugs, allowing the participating CAP physician to switch approved CAP vendors outside of a regular election period in this instance would be prudent. We welcome comments on our proposals.

c. Geographic Area Served by the CAP

In the July 6, 2005 IFC (70 FR 39034 through 39036), we established a single, national competitive acquisition area for the initial stage of the CAP. This national distribution area included the 50 States, the District of Columbia, Puerto Rico, and U.S. territories. We recognized that designating a single national area might limit participation to those vendors that could compete to bid and supply drugs nationally, but we indicated this approach was a part of the phase-in plan for the CAP. We also discussed potential phase-in options for the future, stating that smaller areas might become a solution as the program expanded.

According to the vendor community, certain areas of the United States (especially Alaska, Hawaii, and the Territories) currently present logistical challenges and are associated with high drug shipping costs. Moreover, physician participation in these areas has been low; in 2008, physicians from Alaska, Hawaii, and the Territories represented less than 2 percent of total

participating CAP physicians.
Temporarily limiting the geographic areas served by the CAP could help limit costs and risks for approved CAP vendors associated with shipping drugs to distant parts of the country. However, we believe that the CAP is intended to provide services to all Medicare physicians (including those in distant parts of the country), and therefore, we do not believe that a limitation on the geographic area in which the CAP is available should be permanent.

Section 1847B(a)(1)(B) of the Act specifically requires the Secretary to phase-in the CAP with respect to the categories of drugs and biologicals in the program, in such a manner as the Secretary determines to be appropriate. We believe that this provision, particularly in conjunction with the statutory definition of a competitive acquisition area as "an appropriate geographic region established by the Secretary" provides broad authority for the Secretary to phase in the CAP with respect to the geographical areas in which the program would be implemented. As stated in the July 6, 2005 IFC, we considered several factors when defining geographic areas for the CAP, including aspects of vendors and their distribution systems, such as current geographic service areas, the density of distribution centers, the distances drugs and biologicals are typically shipped, and costs associated with shipping and handling (70 FR 39035). Taking these factors into consideration again, and considering entities who have bid on, or expressed interest in bidding on approved CAP vendor contracts, we believe that it is appropriate to use the authority granted under the Statute to temporarily narrow the area served by the CAP during the program's re-implementation. We appreciate the logistical issues associated with shipping drugs to remote areas and the uncertainties associated with transportation costs that have been described by the potential vendor community; however, we are reluctant to significantly reduce the area served by the CAP because at some point, the approved CAP vendor's volume would be affected and the likelihood of obtaining volume based discounts would decrease.

At this time, we are proposing to designate the CAP competitive acquisition area as the 48 contiguous States and the District of Columbia for the next round of CAP contracting. This change in the geographic area that is served by the CAP is meant as an interim measure under our phase-in authority and the statutory definition of a competitive acquisition area. We

believe that omitting Alaska, Hawaii, and the Territories from the CAP competitive acquisition area at this time will balance the need to revise the CAP to attract more vendors with the need to offer the maximum number of physicians a meaningful opportunity to participate. We believe that this proposal will encourage potential vendors to participate in the CAP because it would temporarily omit areas associated with low physician participation, long shipping times, and high shipping costs. Furthermore, this measure is unlikely to significantly decrease CAP drug order volume relative to historical physician participation in the CAP. However, we are aware that our proposal temporarily eliminates the CAP option for physicians in the areas not included in this CAP competitive acquisition area. Therefore, we are not proposing this definition of the CAP geographical area as a permanent solution. We will continue to assess the CAP and update plans for phase in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to physicians in Alaska, Hawaii, and the Territories. We will also continue to consider modifying the definition of competitive acquisition area on the basis of regions, States, or some smaller geographic area, which might expand the number of vendors that could bid to participate in the program (70 FR 39036). We welcome comments on our proposal.

d. CAP Drug Stock at the Physician's

Our discussion about the CAP emergency restocking option in the July 6, 2005 IFC indicated that a participating CAP physician could not maintain a stock of an approved CAP vendor's drug in his or her inventory. This was done because we had reservations about potential program integrity and drug diversion issues (70 FR 39047).

Since that time, we have gained operational experience with the CAP and a better understanding of the ordering and drug delivery process. We have also received additional public feedback about the different ways that the program could be refined. Further, our experience with the CAP indicates that our concerns over program integrity and drug diversion have not come to pass. For example, we have received no complaints and have no information indicating that diversion has been a concern. Also, we have not received any negative feedback from the vendor community indicating a concern about

storing CAP drugs in physicians' offices. Therefore, we believe at this time it is appropriate to consider allowing additional flexibility to encourage CAP participation.

Our experience with the CAP, and our increased understanding about the options approved CAP vendors might have for furnishing drugs to a participating CAP physician's office also support considering additional flexibility in this area. For example, we are aware of electronic inventory control and charge capture devices that could be utilized in ways that conform to CAP regulations and are compliant with applicable State and Federal laws. Such devices utilize an electronic transaction based on a physician's order to track the administration of drugs from inventory to a specific patient and to document appropriate charges for the drug. We believe that such systems could fit into the current CAP framework when transactions in such systems are based on a physician's order, because such systems can track inventory, and can be used to capture patient charge data.

For these reasons, we are seeking to clarify our requirements for the manner in which CAP drugs are supplied to participating CAP physicians. Specifically, we are proposing to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. Our proposal is also intended to clarify that entities with alternative approaches to supplying drugs that utilize an electronic transaction are welcome to participate in the CAP bidding process. We believe that this will allow for additional flexibility and efficiency in the ordering and delivery of drugs within the program because it allows for more efficient shipping of approved CAP vendor-owned stock and provides the option of CAP participation for physicians who use or may choose to use such drug inventory management platforms. This proposal does not change our position that a participating CAP physician shall not take title to or pay for CAP drugs, nor does it alter the requirements for information that must be submitted with a prescription order under Section 414.908(a) or the application of HIPAA to such data.

Furthermore, our proposal does not affect the applicability of State licensing requirements for an approved CAP vendor. As stated in the July 6, 2005 IFC (70 FR 39066), either the approved CAP vendor, its subcontractor under the

CAP, or both, must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, if a State requires it, an approved CAP vendor would be required to be licensed as a pharmacy, as well as a distributor. We are not revising the requirements at § 414.908(c) and § 414.914(f)(9), and we note that sections 1847B(b)(6) and 1847B(b)(2)(B) of the Act continue to apply. In order to participate in the CAP successful bidders must continue to submit proof of pharmacy licensure, consistent with applicable State requirements.

Also, this proposal would not modify our definition of "emergency delivery or its corresponding requirements at § 414.902. As we stated in our July 6, 2005 IFC, the intent of the 1-businessday timeframe for emergency deliveries is to address the participating CAP physician's need for more rapid delivery of drugs in certain clinical situations with the approved CAP vendor's ability to ship the drug and have it delivered promptly in a nationwide delivery area (70 FR 39045). The emergency delivery timeframe still applies in situations when CAP drugs are not available in the office for electronic delivery.

Moreover, this proposal does not seek to change the CAP inventory requirements. CAP drugs belong to the approved CAP vendor, and as indicated in the July 6, 2005 IFC (70 FR 39048). participating CAP physicians are required to maintain a separate electronic or paper inventory for each CAP drug obtained. CAP drugs must be tracked separately in some way (for example, an electronic spreadsheet). CAP drugs do not have to be stored separately from a physician's own stock; that is, co-mingling of CAP drug with drug from a participating CAP physician's own private stock is acceptable as long as a record of approved CAP vendor-owned drug is kept in a manner that is consistent with $\S414.908(a)(3)(x)$ and the approved CAP vendor-owned drug can be accounted for, as needed.

Also, this proposal does not affect the CAP emergency restocking requirements. Section 1847B(b)(5) of the Act and § 414.906(e) provide criteria for the replacement of drugs taken from a participating CAP physician's inventory in the event of an emergency situation. When the emergency resupply criteria are met, a participating CAP physician can replace the drugs that were used from his or her own inventory by submitting a prescription order to the approved CAP vendor.

Our proposal seeks to clarify the potential approaches that a bidder may use (separately or in combination) to

supply drugs under the CAP. Our proposal does not seek to specify a particular approach that bidders must use in future responses to CAP bid solicitations or to strictly define the types of entities that could bid on CAP vendor contracts; for example, whether bidders must be pharmacies, drug distributors, or a hybrid of the two; whether bidders must utilize just in time shipping, or electronic inventory transactions to supply CAP drugs. We will consider approving bidders approaches that are consistent with the statutory framework, applicable laws, and regulations. We welcome comments on this issue.

e. Exclusion of CAP Sales From ASP Calculations

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP will be taken into account in computing the ASP under section 1847A of the Act. In the July 6, 2005 IFC, we responded that prices offered under the CAP must be included in ASP calculations (70 FR 39077). This was done because we initially believed that we did not have the statutory authority to exclude prices determined under the CAP from the computation of ASP under section 1847A of the Act. Section 1847A(c)(2) of the Act contains a specific list of sales that are exempt from the ASP calculation, and sales to approved CAP vendors operating under CAP are not included on that list (70 FR 39077). Comments received in response to the July 6, 2005 IFC opposed this policy (70 FR 70479).

Ultimately, as stated in the November 21, 2005 IFC, we recognized commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. Therefore, we excluded units of CAP drugs that are administered to beneficiaries by participating CAP physicians from the ASP calculation for the initial 3-year approved CAP vendor contract period (70 FR 70479). Accordingly, the definition of "Unit" at § 414.802 was also revised to reflect this exclusion.

In our August 18, 2006 interim final rule, we further addressed concerns

pertaining to our definition of Unit. We published a PRA notice regarding a proposed modification of the OMBapproved ASP information collection requirements (CMS Form 10110 (OMB #0938-0921) about the collection of the number of CAP units excluded from the ASP calculation. In response, a commenter expressed concern over manufacturers' reliance on approved CAP vendors for information about the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians (71 FR 48132). Since approved CAP vendors are the only entities with direct information on CAP units administered, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians placed the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information from approved CAP vendors. Further, the commenter noted that manufacturers may not have timely access to this information and that they could not independently confirm its accuracy (71 FR 48132). Additional feedback received as part of our ongoing work with manufacturers also indicated that they were concerned that they would have difficulty obtaining information from approved CAP vendors that would be necessary to accurately exclude administered CAP units from the ASP calculation (71 FR 48132).

Therefore, we further revised the definition of unit to clarify that for the initial 3-year contract period under the CAP units of CAP drugs sold to an approved CAP vendor for use under the CAP would be excluded from the calculation of ASP (70 FR 48132).

In the July 6, 2005 and August 18, 2006 IFCs, we stated that we would examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP (70 FR 70480 and 71 FR 48132, respectively). Since then, operational experience has not indicated a reason for changing our policy of excluding CAP units sold to approved CAP vendors for use under the CAP from ASP calculations. Therefore, we are proposing to permanently exclude drugs supplied under the CAP from ASP calculations and make conforming changes to the definition of unit at § 414.802. We believe that this proposal will continue to promote the separation and independence of the two drug payment models. We welcome comments on this proposal.

f. Annual CAP Payment Amount Update Mechanism

In the July 6, 2005 IFC (70 FR 39076), we described a two-step process to calculate RNAC-based price adjustment if there is a change in the RNAC reported by a particular approved CAP vendor. We stated that "we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices." The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that all successful bidders would participate in the CAP.

However, during the first round of CAP contracting, after offering more than one contract, we entered into a contract with only one successful bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. In the CY 2009 PFS proposed rule, we stated that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two-step calculation based on the approved CAP vendor's RNAC, as well as the calculation of a median of adjusted bid prices.

We also posted our approach on the Approved CAP Vendor page of the CMS CAP Web site at http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp. The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

Then, in the CY 2009 PFS proposed rule (73 FR 38522 through 38523), we proposed to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We proposed that the average of the approved CAP vendor-supplied RNAC data would be used as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four

approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendors' RNAC). Similarly, if there were five successful bidders but only three chose to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated

CAP payment amount.

Our approach in the CY 2009 PFS proposed rule was intended to provide us with a flexible method for updating CAP prices, to be consistent with our original policy as stated in the July 6, 2005 IFC, and to account for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. However, our approach was limited in scope because it was made during a contract period and during bidding for an upcoming contract and we did not want to make any significant changes to the CAP program which could affect contractual obligations. Furthermore, we received a comment in response to the CY 2009 PFS proposed rule that suggested the elimination of the proxy procedure so that payments would be based on actual data from participating vendors and would better reflect experience within the program. After additional consideration, we believe that it would be prudent to simplify and update our 2009 proposal in order to account for successful bidders who choose not to participate in the CAP, possible changes in the number of approved CAP vendors over the life of a 3-year CAP contract, and to allow for flexibility in setting the frequency of payment amount adjustments as described in section a. above. We believe that our updated proposal is easier for the vendor community to understand and for us to implement. Furthermore, our revised proposal is not constrained by concerns about the impact of changes on an active contract.

We are proposing to clarify that the RNAC-based adjustment calculations are intended to apply only to approved CAP vendors (not all bidders), and that the most recent CAP payment amount

(for example, the previous year's or the previous quarter's payment amount) will be the starting point for making the subsequent period's adjustment. Simply put, we are proposing to eliminate the use of proxy data for bidders that are no longer participating in the program. Instead, we propose to use RNAC data only from approved CAP vendors that are participating in the CAP at the time that an RNAC-based price update is being calculated. We are also clarifying that the starting point for the payment amount adjustment is the most recent payment amount. The percent change calculated from each participating approved CAP vendor's RNAC data will be applied to the most recent payment amount by recomputing the single price using the median of all participating

vendors' adjusted prices. For example, if quarterly adjustments beginning at the start of claims processing approved CAP vendor's contract as described in section a. above are implemented, and the post bid period's CAP payment amounts are calculated based on five successful bids, but only four approved CAP vendors are participating when CAP claims processing begins, the RNAC-based payment amount adjustment for the first quarter of CAP claims would be based on RNAC data provided by the four approved CAP vendors that will be furnishing drugs under the CAP. The four approved CAP vendors would be required to submit a quarter of RNAC data within thirty days of the close of the quarter to which the data applied, prior to the beginning of CAP claims processing for the new contract. We would apply the percentage change in RNAC reported by each of the four approved CAP vendors to the CAP payment amounts calculated from successful bids, and the adjusted payment amount would be the median of those four adjusted amounts. Assuming that these four vendors are still furnishing drugs during the second quarter, calculations for the second quarter would apply the RNAC-based adjustment calculated from the four vendors' data to the first quarter's

payment amount.

This process would apply to the composite bid drug list as amended by rulemaking, meaning that a single weighted percent change in RNAC is calculated for all drugs in the composite bid list and that single percent change is applied to all drugs in the list. For drugs that are bid as separate line items, such as drugs that were included in addendum B of the 2006 bidding period (see 70 FR 39072 and updated as addendum G in 70 FR 70238) or for drugs that are added during a contract

period, each HCPCS code will be adjusted as a separate line item. Such codes will not be included in the composite, weighted drug list. Our process will continue to assign a single payment amount to all approved CAP vendors that supply a given HCPCS code; we do not intend to have more than one payment amount for any HCPCS code under the CAP or for individual "NOC" drugs described in § 414.906(f)(2)(iv).

This updated approach is flexible, and we believe it can accommodate a variety of scenarios, including a changing number of approved CAP vendors and changes to the frequency with which payment amount updates are made. It provides a straightforward and accurate clarification of the price adjustment mechanism described in regulation text. We believe that this proposal remains consistent with our original preamble language and with our CY 2009 PFS proposal, because it retains the two-step calculation using the percent change in RNAC. Finally, we believe that our approach will eliminate any perception that nonparticipating vendors can significantly affect CAP payment amount adjustments. We welcome comments on our proposal and corresponding regulation text changes at § 414.906(c).

g. 2009 PFS Proposals

(1) Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the November 21, 2005 IFC (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a "physician" in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and other professions such as physician assistants (PAs) who may be able to legally prescribe medications and enroll in Medicare. Our 2005 CAP definition was not intended to exclude these practitioners who are appropriately billing Medicare for legally prescribed medications administered in a capacity that would be classified as incident to a physician's services if the medications were administered by a physician. We are

concerned that the existing CAP definition of a physician is unnecessarily restrictive and could potentially affect access to the CAP for a small segment of providers that should be eligible for participation in the CAP in situations where they currently bill Medicare separately and appropriately.

In the CY 2009 PFS proposed rule (73 FR 38523), we proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a "physician" in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believed that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it was not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

In response to our CY 2009 proposed rule, only a few commenters were concerned about the inclusion of inadequately trained practitioners and risks to patient safety under this expanded definition. Another commenter stated that this definition goes beyond the scope of the provisions in the MMA and the strict definition of "physician" in the statute. However, the majority of comments supported this

proposal.

We did not receive any feedback during the CAP postponement that would lead us to reconsider this proposal. Therefore, we are again proposing to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a "physician" in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's services.

Our proposal is specific to the Part B Drug CAP and does not affect the definition of physician in section 1861(r) of the Act, or the definition of "Medical and Other Health Services" described in section 1861(s) of the Act. This proposal also does not seek to expand the scope of the CAP beyond what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains a program that provides Part B drugs furnished incident to a physician's services. We welcome additional comments on the proposal.

(2) Easing the Restriction on Physicians Transporting CAP Drugs

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. We implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii). However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting CAP drugs where this is permitted by State law and other applicable laws and regulations. We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268).

In the CY 2009 PFS proposed rule (70 FR 38523), we proposed to permit the transportation of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. Because of the 2009 CAP postponement, we did not address this issue in the CY 2009 PFS final rule. However, we did receive the following comments in response to our proposed rule on easing transportation restrictions in the CAP:

• Many commenters indicated that this change would increase program

flexibility and facilitate patient treatment.

- Some commenters were supportive, but also raised concerns about drug integrity and liability, and requested that appropriate safeguards be in place before transportation restrictions were eased.
- Generally, commenters wanted CMS to explicitly delineate standards about voluntary agreements that address concerns about product integrity, liability, transportation procedures, and documentation. One commenter indicated that such standards should be developed through a separate rulemaking period to allow for public comment.
- Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

We also requested and received feedback about the program during the 2009 postponement period. One member of the potential vendor community urged us to be mindful of increased legal liability for an approved CAP vendor if this policy were to be implemented, but also acknowledged that the proposal might substantially increase physician interest in the program.

We continue to be mindful of the concerns expressed by the commenters, and have evaluated both the advantages and disadvantages of easing the restriction on transportation of CAP drugs. Thus, we are again proposing to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. As indicated in our CY 2009 PFS proposed rule, we continue to propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would again like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify

which CAP drug(s) could be transported.

However, our proposal continues to contain certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and participating CAP physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral ("Stark") prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We are proposing to apply these standards to any agreement for the transport of CAP drugs.

We remain concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we are reproposing that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We again welcome comments on these issues, including the identification of who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that this proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who

have office locations in rural areas and/ or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since participating CAP physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We invite comments about this proposal.

(3) Dispute Resolution Process

In the CY 2009 PFS proposed rule (73 FR 38524 through 38525), we discussed two changes to the CAP dispute resolution process. Section 1847B(b)(2)(A)(ii)(II) of the Act requires an approved CAP vendor to have a grievance and appeals process for the resolution of disputes. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and approved CAP vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

(i) Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 outlines the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a participating CAP physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the "approved CAP vendor may resume participation in CAP" if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we proposed in the CY 2009 PFS proposed rule that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917 (73 FR 38525). We believed that this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. This proposal was not finalized due to the 2009 CAP postponement.

Comments submitted in response to our CY 2009 PFS proposed rule supported this proposed clarification and we did not receive additional feedback about this issue after the CAP was postponed. Based on this and our continued need to improve the clarity of our regulations, we are reproposing that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We invite additional comments regarding this proposed issue.

(ii) Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians. As stated at § 414.916(a), "Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS." Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to "[a] participating CAP physician." However, we believe that

the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, in the CY 2009 PFS proposed rule, we proposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. Our proposal also applied to physicians engaged in the reconsideration process outlined in § 414.916(c) and included a conforming change at § 414.914(f)(12). We believed that these changes were in accord with the underlying intent of § 414.916, namely to provide a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians, and we believe that these changes will increase the clarity of our regulations. We also noted that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comments submitted in response to the CY 2009 PFS proposed rule agreed with our proposal. Though we did not finalize this proposal due to the 2009 CAP postponement, we received no comments from the public in response to our request for feedback during the CAP 2009 postponement. Based on positive public feedback and our continued belief that the clarity of our dispute resolution regulations would be improved by being explicit about this issue, we are reproposing to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We have also proposed a conforming change to § 414.914(f)(12). Physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked. We welcome comments on this proposal.

I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

Since August 1, 1983, payment for dialysis services furnished by end-stage renal disease (ESRD) facilities has been based on a composite rate payment system that provides a fixed, prospectively determined amount per dialysis treatment, adjusted for geographic differences in area wage levels. In accordance with section 1881(b)(7) of the Act, separate composite rates were established for hospital-based and independent ESRD facilities. The composite rate is designed to cover a package of goods and services needed to furnish dialysis treatments that include, but not be limited to, certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite rate, other injectable drugs and laboratory tests medically necessary for the care of the dialysis patient are separately billable. Effective on August 1, 1983, the base composite rates per treatment were \$123 for independent ESRD facilities and \$127 for hospital-based ESRD facilities. The Congress has enacted a number of adjustments to the composite rate since that time.

Section 623 of the MMA amended section 1881 of the Act to require changes to the composite rate payment methodology, as well as to the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities. Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, requires the establishment of a basic case-mix adjusted composite payment system that includes services comprising the composite rate and an add-on to the composite rate component to account for the difference between current payments for separately billed drugs and the revised drug pricing specified in the statute. In addition, section 1881(b)(12) of the Act requires that the composite rate be adjusted for a number of patient characteristics (case-mix) and section 1881(b)(12)(D) of the Act gives the Secretary discretion to revise the wage indices and the urban and rural definitions used to develop them. Finally, section 1881(b)(12)(E) of the Act imposes a budget neutrality (BN) adjustment, so that aggregate payments under the basic case-mix adjusted composite payment system for CY 2005 equal the aggregate payments for the same period if section 1881(b)(12) of the Act did not apply.

Before January 1, 2005, payment to both independent and hospital-based

facilities for the anti-anemia drug, erythropoietin (EPO) was established under section 1881(b)(11) of the Act at \$10.00 per 1,000 units. For independent ESRD facilities, payment for all other separately billable drugs and biologicals is based on the lower of actual charges or 95 percent of the average wholesale price (AWP). Hospital-based ESRD facilities were paid based on the reasonable cost methodology for separately billed drugs and biologicals (other than EPO) furnished to dialysis patients. Changes to the payment methodology for separately billed ESRD drugs and biologicals that were established by the MMA affected payments in both CY 2005 and CY 2006.

1. CY 2005 Revisions

In the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334), we implemented section 1881(b) of the Act, as amended by section 623 of the MMA, and revised payments to ESRD facilities. These revisions were effective January 1, 2005, and included an update of 1.6 percent to the composite rate component of the payment system; and a drug add-on adjustment of 8.7 percent to the composite rate to account for the difference between pre-MMA payments for separately billable drugs and payments based on revised drug pricing for 2005 which used acquisition costs. Effective April 1, 2005, the CY 2005 PFS final rule with comment period also implemented case-mix adjustments to the composite rate for certain patient characteristics (that is, age, low body mass index, and body surface area).

In addition, to implement section 1881(b)(13) of the Act, we revised payments for drugs billed separately by independent ESRD facilities, paying for the top 10 ESRD drugs based on acquisition costs (as determined by the OIG) and for other separately billed drugs at the average sales price +6 percent (hereafter referred to as ASP+6 percent). Hospital-based ESRD providers continued to receive cost-based payments for all separately billable drugs and biologicals except for EPO which was paid based on average acquisition cost.

2. CY 2006 Revisions

In the CY 2006 PFS final rule with comment period (70 FR 70161), we implemented additional revisions to payments to ESRD facilities under section 623 of the MMA. For CY 2006, we further revised the drug payment methodology applicable to drugs furnished by ESRD facilities. All separately billed drugs and biologicals furnished by both hospital-based and

independent ESRD facilities are now paid based on ASP+6 percent.

We recalculated the 2005 drug add-on adjustment to reflect the difference in payments between the pre-MMA AWP pricing and the revised pricing based on ASP+6 percent. The recalculation did not affect the actual add-on adjustment applied to payments in 2005, but provided an estimate of what the adjustment would have been had the 2006 payment methodology been in effect in CY 2005. The drug add-on adjustment was then updated to reflect the expected growth in expenditures for separately billable drugs in CY 2006.

As of January 1, 2006, we also implemented a revised geographic adjustment authorized by section 1881(b)(12) of the Act. As part of that change, we—

- Revised the labor market areas to incorporate the Core-Based Statistical Area (CBSA) designations established by the Office of Management and Budget (OMB);
- Eliminated the wage index ceiling and reduced the floor to 0.8500; and
- Revised the labor portion of the composite rate to which the geographic adjustment is applied.

We also provided a 4-year transition from the previous wage-adjusted composite rates to the current wage-adjusted rates. For CY 2006, 25 percent of the payment was based on the revised geographic adjustments, and the remaining 75 percent of payment was based on the old metropolitan statistical area-based (MSA-based) payments.

In addition, section 5106 of the DRA provided for a 1.6 percent update to the composite rate component of the basic case-mix adjusted composite payment system, effective January 1, 2006. As a result, the base composite rate was increased to \$130.40 for independent ESRD facilities and \$134.53 for hospital-based providers. For 2006, the drug addon adjustment (including the growth update) was 14.5 percent.

- 3. CY 2007 Updates In the CY 2007 PFS final rule with comment period (71 FR 69681), we implemented the following updates to the basic case-mix adjusted composite payment system:
- An update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment of 1.052818 to the wage index for CY 2007.
- A method to annually calculate the growth update to the drug add-on adjustment required by section 1881(b)(12) of the Act, as well as a growth update to the drug add-on adjustment of 0.5 percent for CY 2007. Therefore, effective January 1, 2007 the

drug add-on adjustment was increased to 15.1 percent.

In addition, section 103 of the MIEA-TRHCA established a 1.6 percent update to the composite rate portion of the payment system, effective April 1, 2007. As a result, the current base composite rate was \$132.49 for independent facilities and \$136.68 for hospital-based providers. Also, the effect of this increase in the composite rate portion of the payment system was a reduction in the drug add-on adjustment to 14.9 percent, effective April 1, 2007. Since the statutory increase only applied to the composite rate, an adjustment to the drug add-on percent was needed to maintain the drug add-on amount constant.

4. CY 2008 Updates

In the CY 2008 PFS final rule with comment period (72 FR 66280), we implemented the following updates to the basic case-mix adjusted payment system:

• A growth update to the drug add-on adjustment of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate increased from 14.9 percent to 15.5 percent.

• An update to the wage index adjustments to reflect the latest hospital wage data, including a wage index BN adjustment of 1.055473 to the wage index for CY 2008.

For CY 2008, consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), we implemented the third year of the transition to the CBSA-based wage index. In addition, the wage index floor was reduced from 0.8000 to 0.7500. After applying the wage index BN adjustment of 1.055473, the wage index floor was 0.7916.

5. CY 2009 Updates

Subsequent to the July 7, 2008 publication of the CY 2009 PFS proposed rule, section 153 of the MIPPA mandated changes in ESRD payment including a 1 percent increase to the composite rate, effective for services furnished on or after January 1, 2009 and 2010 and before January 1, 2010.

Specifically, section 153(a) of the MIPPA updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act to revised payments to ESRD facilities. The revisions that were effective January 1, 2009, included the update of 1 percent to the composite rate component of the payment system noted above, and the establishment of a site neutral composite rate for both hospital-based and independent dialysis facilities that reflected the labor share based on the labor share otherwise applied to

independent dialysis facilities. The labor share for both hospital-based and independent dialysis facilities was 53.711. In the CY 2009 final rule with comment period (73 69754 through 69761), we implemented the following updates to the basic case-mix adjusted composite payment system:

• As required by updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act, we applied a 1 percent increase to the independent dialysis facility's CY 2008 composite rate of \$132.49, which resulted in a CY 2009 base composite rate for both hospital-based and independent dialysis facilities of \$133.81:

• A zero growth update to the drug add-on adjustment of 15.2 percent to the composite rates for 2009 as required by section 1881(b)(1)(F) of the Act (resulted in a \$20.33 per treatment drug add-on amount):

Prior to MIPPA, the proposed drug add-on adjustment was 15.5 percent. Since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, the effect of the one percent increase in the composite rate portion of the payment system, effective January 1, 2009, reduced the drug add-on adjustment from 15.5 to 15.2 percent. Since the statutory increase only applied to the composite rate, this adjustment to the drug add-on percent was needed to ensure that the total drug add-on dollars remained constant.

- An update to the wage index adjustment to reflect the latest available wage data, including a wage index BN adjustment of 1.056672 to the wage index for CY 2009;
- For CY 2009, the completion of the 4-year transition from the previous wage-adjusted composite rates to the CBSA wage-adjusted rates, where payment is based on 100 percent of the revised geographic adjustments; and
- A reduction of the wage index floor from 0.7500 to 0.7000. After applying the wage index BN adjustment of 1.056672, the wage index floor was 0.7397.

6. CY 2010 Proposals

For CY 2010, we are proposing the following updates to the composite rate payment system:

- An update to the drug add-on adjustment to the composite rate, using a refined methodology for projecting growth in drug expenditures;
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment; and
- A reduction to the ESRD wage index floor from 0.7000 to 0.6500.

As stated above, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increased the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. The 1.0 percent increases the current composite rate of \$133.81 to \$135.15 for services furnished on or after January 1, 2010.

a. Proposed Update to the Drug Add-on Adjustment to the Composite Rate

Section 623(d) of the MMA added section 1881(b)(12)(B)(ii) of the Act which requires establishing an add-on to the composite rate to account for changes in the drug payment methodology stemming from enactment of the MMA. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the AWP payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to ASP pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in CY 2006, we establish an annual increase to the drug add-on to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system. The CY 2009 drug add-on adjustment to the composite rate was 15.2 percent. The drug add-on adjustment for CY 2009 reflected a zero increase. This computation is explained in detail below and in the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757).

(i) Estimating Growth in Expenditures for Drugs and Biologicals for CY 2009

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect "the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *" By referring to "expenditures", we stated previously that we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that

uses the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth in conjunction with 2 years of ESRD drug data to estimate per patient utilization growth. We indicated that this interim methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ESRD drug expenditure data to project the growth in ESRD drug expenditures.

However, due to the declining ASP prices, we no longer believed that using the PPI as a proxy for pricing growth was appropriate. Accordingly, for CY 2009, we revised the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation. Due to the declining trend in ASP pricing and utilization, we calculated a decrease in the drug add-on adjustment, and applied a zero update to the drug add-on adjustment (73 FR 69755 through 69757).

(ii) Estimating Growth in Expenditures for Drugs and Biologicals in CY 2010

Since we now have 3 years of drug expenditure data based on ASP pricing, we have reevaluated our methodology for estimating growth in drug expenditures. We believe that 3 years of drug expenditure data based on ASP pricing is sufficient to project drug expenditure growth based on trend analysis. Therefore, for CY 2010, we are proposing to use trend analysis from drug expenditure data to update the per treatment drug add-on adjustment. In the CY 2008 PFS final rule with comment period, we stated that when we had 3 consecutive years of ASPbased historical drug expenditure data, we intended to reevaluate our methodology for estimating growth in drug add-on adjustment (72 FR 66281). We also stated that we expected 2010 would be the earliest we could consider using trend analysis to update the drug add-on adjustment (72 FR 66281).

For CY 2010, we propose to estimate per patient growth in drug expenditures by removing growth in ESRD enrollment from growth in total drug expenditures.

To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2008. First we had to estimate the total drug expenditures for all ESRD facilities in CY 2008. For this proposed rule, we used the final CY 2006 and the final CY 2007 ESRD claims data and the latest available CY 2008 ESRD facility claims, updated through December 31, 2008 (that is, claims with dates of service from January 1 through December 31,

2008, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2008). For the CY 2010 PFS final rule, we plan to use additional updated CY 2008 claims with dates of service for the same timeframe. This updated CY 2008 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2009

While the December 2008 update of CY 2008 claims used in this proposed rule is the most current available claims data, we recognize that it does not reflect a complete year, as claims with dates of service towards the end of the year have not all been processed. To more accurately estimate the update to the drug add-on, aggregate drug expenditures are required. Based on an analysis of the 2007 claims data, we inflated the CY 2008 drug expenditures to estimate the June 30, 2009 update of the 2008 claims file. We used the relationship between the December 2007 and the June 2008 versions of 2007 claims to estimate the more complete 2008 claims that will be available in June 2009 and applied that ratio to the 2008 claims data from the December 2008 claims file. In previous years, we did this separately for EPO, the other top 10 Part B separately billable drugs, and the remaining separately billable drugs for independent and hospitalbased ESRD facilities. All components were then combined to estimate aggregate CY 2008 ESRD drug expenditures. However, we do not believe that creating this estimate using this level of detail (by separately estimating EPO, the other top 10 separately billable drugs, and the remaining separately billable drug for independent and hospital-based ESRD facilities and then combining these components) provides more accuracy. For this reason, we are making this adjustment in aggregate for all separately billable drugs for CY 2008 ESRD drug expenditures. The net adjustment to the CY 2008 claims data is an increase of 11.1 percent to the 2008 expenditure data. This adjustment allows us to more accurately compare the 2007 and 2008 drug expenditure data to estimate per patient growth. As stated earlier in this section, we plan to use additional updated CY 2008 claims in the CY 2010 PFS final rule with comment period. We also note that the top 11 drugs continue to represent 99.7 percent of total expenditures in CY 2008 for separately billable drugs furnished to ESRD patients.

Using the full-year 2008 drug expenditure figure, we calculated the average annual change in drug

expenditures from 2006 through 2008. This average annual change showed a decrease of 2.2 percent for this timeframe. We propose to use this 2.2 percent decrease to project drug expenditures for both 2009 and 2010.

(iii) Estimating Per Patient Growth

Once we had the projected growth in drug expenditures from 2009 to 2010, we then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth, (which includes price and utilization combined) which is what we believe that section 1881(b)(12)(F) of the Act requires us to use to update the drug add-on adjustment. As we described in section II.I.6.a.(ii) of this proposed rule, we now have 3 years of drug expenditure data based on ASP pricing, and for CY 2010 we are proposing to use trend analysis from this data to update the per treatment drug add-on adjustment. To calculate the per patient growth between CYs 2009 and 2010, we removed the enrollment component by using the estimated growth in enrollment data between CY 2009 and CY 2010. This was approximately 1.3 percent. To do this, we divided the total drug expenditure change between 2009 and 2010 (1.000–0.222 = 0.978) by enrollment growth of 1.3 percent (1.013) for the same timeframe. The result is a per patient growth factor equal to 0.965, (0.978/1.013 = 0.965). Thus we are projecting a 3.5 percent decrease in per patient growth in drug expenditures between 2009 and 2010.

b. Applying the Proposed Growth Update to the Drug Add-On Adjustment

In CY 2006, we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of \$18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth

update factor of 4.03 percent to the \$18.88 per treatment drug add-on amount for an updated amount of \$19.64 per treatment (71 FR 69684). For CY 2008, the per treatment drug add-on amount was updated to \$20.33. In the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757), we applied a zero update to per treatment drug add-on amount which left it at \$20.33. As discussed in detail below, for CY 2010, we are again proposing no update to the per treatment drug add-on amount of \$20.33 established in CY 2008.

c. Proposed Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 2.2 percent reduction in drug expenditures between CY 2009 and CY 2010. Combining this reduction with a 1.3 percent increase in enrollment, as described in section (a)(iii) above, we are projecting a 3.5 percent decrease in per patient growth of drug expenditures between CY 2009 and CY 2010. Therefore, we are projecting that the combined growth in per patient utilization and pricing for CY 2010 would result in a negative update equal to -3.5 percent. However, similar to last year and as indicated above, we are proposing a zero update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that "the Secretary shall annually increase" the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates "annually increase" to mean a positive or zero update to the drug add-on. Therefore, we propose to apply a zero update, and to maintain the \$20.33 per treatment drug add-on amount for CY 2010. The current \$20.33 per treatment drug add-on reflected a 15.2 percent drug add-on adjustment to the composite rate in effect for CY 2009. Given that the MIPPA mandates a 1 percent increase to the composite rate (effective January 1, 2010), however, as discussed earlier in this section, this results in a decrease in the CY 2009 drug add-on adjustment of 15.2 to 15.0 to keep the drug add-on at \$20.33. Therefore, we are proposing that the drug add-on adjustment to the composite rate for CY 2010 is 15.0 percent.

d. Proposed Update to the Geographic Adjustments to the Composite Rate

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to

revise the wage indexes previously applied to the ESRD composite rate. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/ rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions as used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational

e. Proposed Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area designations to develop revised urban/ rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at http:// www.whitehouse.gov/omb/bulletins/ b03-04.html. In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at http://www.whitehouse.gov/omb/ bulletins/index.html.

f. Proposed Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD wage index values for CY 2010 were developed from FY 2006 wage and employment data obtained from the

Medicare hospital cost reports. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We propose to use the same methodology for CY 2010, with the exception that FY 2006 hospital data would be used to develop the CY 2010 wage index values. For a detailed description of the development of the proposed CY 2010 wage index values based on FY 2006 hospital data, see the FY 2010 IPPS proposed rule (74 FR 24145). Section III.G, of the preamble to the FY 2010 IPPS proposed rule, "Method for Computing the Proposed FY 2010 Unadjusted Wage Index" describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at http://www.cms.hhs.gov/ AcuteInpatientPPS/WIFN/list.asp. The wage data are located in the section entitled, "FY 2010 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.'

In the CY 2009 final rule with comment period (73 FR 69758 and 69759), we indicated that the CY 2009 was the final year of the transition period and each ESRD facility's composite payment rate would be based entirely on its applicable CBSA-based wage index value.

g. Proposed Reduction to the ESRD Wage Index Floor

In the CY 2009 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (73 FR 63758). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor. For CY 2010, we are proposing to reduce the wage index floor from 0.70 to 0.65. We also anticipate that we may reduce the floor gradually until full implementation of the ESRD PPS required by section 1881(b)(14) of the Act.

h. Proposed Wage index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there

are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980), and rural Massachusetts. For CY 2006, CY 2007, CY 2008, and CY 2009, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville, GA, we calculated the CY 2006, CY 2007, CY 2008, and CY 2009 wage index value based on the average wage index value for all urban areas within the State of Georgia.
- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. As discussed below, we adopted an alternative methodology for CYs 2008 and 2009.
- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2009, we applied the ESRD wage index floor to rural Puerto Rico as well. We note that there are currently no ESRD facilities located in rural Puerto Rico.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts and continued to apply this methodology in CY 2009. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts) and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term "contiguous" to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA and CBSA 39300, Providence-New Bedford-Fall River, RI-MA. We are proposing to use the same methodology for CY 2010. Under this methodology, the CY 2010 proposed wage index values for CBSA 12700 (Barnstable Town, MA—1.2629) and CBSA 39300 (Providence-New Bedford-Fall River, RI-MA-1.0792) averages results in an imputed proposed wage index value of 1.1711 for rural Massachusetts in CY 2010.

For rural Puerto Rico, for CY 2010, all areas in Puerto Rico that have a wage index are eligible for the proposed ESRD wage index floor of 0.65. Therefore, we propose to continue applying the proposed ESRD wage index floor of 0.65 to facilities that are located in rural Puerto Rico.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we propose to apply the same methodology used to impute a wage index value that we used in CY 2009. Specifically, we utilize the average wage index value for all urban areas within the State of Georgia. That results in a proposed CY 2010 wage index value of 0.9029 for the Hinesville-Fort Stewart GA CBSA.

In the CY 2009 PFS final rule with comment period (73 FR 69759 through 69760), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

For CY 2010, we are proposing to use the FY 2010 wage index data (collected from cost reports submitted by hospital for cost reporting periods beginning FY 2006) to compute the ESRD composite payment rates effective beginning January 1, 2010.

i. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, required that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2010 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the casemix adjustments required by the MMA. As we are not proposing any changes to the case-mix measures for CY 2010, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2010. As in CY 2009, for CY 2010, we propose to apply the wage-index BN adjustment factor of 1.057888 directly to the ESRD wage index values. Because the ESRD wage index is only applied to

the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2010 wage index BN adjustment factor (1.057888), we used the FY 2006 prefloor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2008 outpatient claims (paid and processed as of December 31, 2008), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at

http://www.cms.hhs.gov/
DialysisFacilityCompare/. The FY 2006
hospital wage index data for each urban
and rural locale by CBSA may also be
accessed on the CMS Web site at http://
www.cms.hhs.gov/AcuteInpatientPPS/
WIFN/list.asp. The wage index data are
located in the section entitled, "FY 2010
Proposed Rule Occupational Mix
Adjusted and Unadjusted Average
Hourly Wage and Pre-Reclassified Wage
Index by CBSA."

Using treatment counts from the 2008 claims and facility-specific CY 2009 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2009. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2010. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the proposed ESRD wage index for CY 2010. The total of these payments became the new CY 2010 amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA revised section 1881(b)(12)(G) of the Act and provided for an update of 1 percent to the composite rate component of the payment system effective January 1, 2010. We note that when computing the new CY 2010 amount, we did not include this 1 percent increase because the BN adjustment would negate the

After comparing these two dollar amounts (target amount divided by the new CY 2010 amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2010 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.6500 is applied whenever appropriate. The proposed wage BN adjustment factor is 1.057888.

To ensure BN, we also must apply the BN adjustment factor to the proposed

wage index floor of 0.6500 which results in a proposed adjusted wage index floor of 0.6876 (0.6500 \times 1.057888) for CY 2010.

j. ESRD Wage Index Tables

The CY 2010 ESRD wage index tables are located in Addenda F and G of this proposed rule.

J. Discussion of Chiropractic Services Demonstration

1. Background

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Under Medicare, coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include "care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided." The 2-year demonstration was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of the MMA requires the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented."

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess budget neutrality (BN) and how chiropractor fees would be adjusted should the demonstration result in costs higher than those that would occur in the absence of the demonstration. We stated we would assess BN by determining the change in costs based on a pre-post comparison of costs and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites

and control sites. We also stated we would not limit our analysis to reviewing only chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs. If the demonstration was not budget neutral, we anticipated making reductions in the CY 2010 and CY 2011 physician fee schedules. We proposed that if we determined that the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, we would implement the adjustment over a 2-year period. However, if the adjustment was less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period.

2. Analysis of Demonstration

Brandeis University, the demonstration evaluator, used two approaches in examining BN. The "All Neuromusculoskeletal Analysis (NMS)" reflects an intent-to-treat approach whereby the utilization of all beneficiaries who received any Medicare covered services for neuromusculoskeletal conditions in the demonstration areas was examined. This method is potentially subject to large external forces because of its inclusion of all beneficiaries including those who did not use chiropractic services and who would not become users of chiropractic services even with expanded coverage for them. Therefore, a second analysis, termed the "Chiropractic User Analysis" was conducted to examine only the subset of beneficiaries who used chiropractic services for the treatment of their neuromusculoskeletal conditions. Both approaches use hierarchical linear modeling of costs over 3 years—1 year prior to the demonstration and the 2 years of the demonstration. We posted a report describing these analyses on CMS Web site at http:// www.cms.hhs.gov/reports/downloads/

MMA651 BudgetNeutrality.pdf. The results of both analyses indicate that the demonstration was not budget neutral. In the "All NMS Analysis," which measured the costs of the demonstration on all beneficiaries who received services for a neuromusculoskeletal condition in the demonstration areas in comparison to beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was \$114 million. In the "Chiropractic User Analysis," which measured the costs of the demonstration among beneficiaries who used expanded chiropractic services to treat a

neuromusculoskeletal condition in the demonstration areas, in comparison to beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was \$50 million.

Both approaches to assessing BN have strengths and limitations. The "All NMS Analysis" provides the broadest view of the Medicare population that would have been eligible for the demonstration's expanded coverage of chiropractic services. Because it includes all beneficiaries with neuromusculoskeletal conditions, it guards against validity threats of selection. However, this approach creates a large heterogeneous group which may only include a small proportion of chiropractic service users. Basing estimates of BN on such a large heterogeneous group increases the potential for changes in the use of services seldom affected by chiropractors to be falsely attributed to the demonstration, which could result in the costs of the demonstration appearing to be larger than they actually were.

We believe the BN estimate should be based on the "Chiropractic User Analysis" because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them. Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group. Therefore, we are proposing to adjust the Medicare PFS for all chiropractors using the estimate provided in the "Chiropractic User Analysis."

The CMS Office of the Actuary (OACT) estimates chiropractic expenditures in CY 2010 to be approximately \$487 million based on actual Medicare spending for chiropractic services for the most recent available year. Because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we are proposing to recoup the \$50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period.

This approach reflects a change from our BN discussion in the CY 2006, 2007, and 2008 PFS rules, which was described previously in this section. We would recoup \$10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. We believe that spreading this adjustment over a longer period of time and in equal increments will minimize its potential negative impact on chiropractic practices.

3. Payment Adjustment

To implement the required BN adjustment, we propose to reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942). Payment under the PFS for these codes would be reduced by 2 percent. As stated in prior PFS rules, application of the BN adjustment would be specific to these three codes which represent the "chiropractic fee schedule" because they are the only chiropractic codes recognized under the PFS. We are proposing to reflect this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. This would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs. The RVUs published in Addendum B and posted on our Web site would not show this reduction but would be annotated to state that the reduction resulting from the chiropractic demonstration is not reflected in the RVUs.

K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a Medicare provider that furnishes respiratory therapy services among other services. In § 485.70, we set forth the personnel qualifications that must be satisfied by a CORF as a condition of participation under § 485.58 and as a condition of coverage of CORF services, including personnel qualifications for respiratory therapists providing CORF respiratory therapy services.

In the CY 2009 PFS proposed rule (73 FR 38502) and subsequent final rule with comment period (73 FR 69942), we revised the definition of a respiratory therapist under § 485.70(j). The change in the definition of respiratory therapist was intended to ensure accuracy in reference to persons who are qualified to perform respiratory therapy and to ensure that language regarding these professionals is consistent with current

industry requirements for education, training, and practice.

Prior to its modification by the CY 2009 PFS final rule with comment period, § 485.70(j) reflected the qualifications for "Certified Respiratory Therapists (CRTs)" and "Registered Respiratory Therapists (RRTs)" as terms commonly used by the professional industry to identify persons furnishing respiratory therapy services.

Since publication of the CY 2009 PFS final rule with comment, we have been informed by the industry that the changes made in the definition of respiratory therapist exclude a category of professional that has completed the requirements of a CRT, has completed a nationally accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exam for respiratory therapists (RTs), and is eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but has not yet passed the examination. These persons are referred to in the industry as Certified Respiratory Therapists (CRTs).

Because it is our policy that Medicare payment is available for respiratory services provided to Medicare beneficiaries in a CORF only if provided by a respiratory therapist meeting the qualifications set forth in § 485.70(j), payment is not available for respiratory services provided by CRTs in the CORF setting. We note that personnel qualifications for respiratory therapists previously set forth at § 485.70(j) prior to its modification by the CY 2009 PFS final rule with comment period did not exclude this category of personnel from the definition of respiratory therapist. We have also heard from CRTs and from CORFs that this change has limited the availability of respiratory therapy services to Medicare beneficiaries in certified CORFs, as many of these services were provided by CRTs. Thus, in modifying the definition of respiratory therapist in the CY 2009 PFS final rule with comment period, we may have inadvertently impacted access to respiratory therapy services for some Medicare beneficiaries.

Thus, we are proposing to modify the definition of respiratory therapist and to clarify the terms that are used to identify those persons who furnish respiratory services in CORFs in § 485.70(j) to include CRTs, that is those individuals who have completed a nationally accredited educational program for respiratory therapists and are eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but who have not yet passed

the examination. The change in the definition we are proposing would permit CRTs to furnish respiratory therapy services to Medicare beneficiaries in the CORF setting.

In this proposed rule, we intend to assure that persons who were qualified to furnish respiratory therapy services to patients in CORFs prior to the finalization of CY 2009 PFS final rule with comment period (73 FR 69942), will continue to qualify to furnish RT services to CORF patients under this

proposed rule.

We invite public comment on the proposed change to § 485.70(j). We are also seeking comments from the industry regarding the difference in services furnished by the different levels of professionals who provide RT services in CORFs. We welcome such comments to be descriptive and both quantitative and qualitative in nature to the extent possible.

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)

Section 1834(1)(9) of the Act provides that for "ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which transportation originates in a rural area * * * or in a rural census tract of a metropolitan statistical area * * * the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than 1/2 of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area." Thus, the statute authorized a rural mileage bonus for miles 18 through 50 for ground ambulance services furnished on or after July 1, 2001 and prior to January 1, 2004. This provision was implemented in $\S414.610(c)(5)(i)$, but the regulation text does not currently specify the statutory time period during which this rural mileage bonus was effective. In the "Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004" final rule with comment period (68 FR 67960, 67961), we acknowledged that we inadvertently omitted from the regulation text the time period during which this statutory adjustment was applicable, and stated we were "revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period." Thus, in the "Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004" final rule with comment period, we

revised the regulation to include the time period during which the adjustment is applicable (68 FR 67963). However, the revised language specifying the statutory time period was dropped inadvertently from the regulation text when § 414.610(c)(5) was later republished in the "Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004" interim final rule (69 FR 40288, 40292).

In this proposed rule, we are reinstating the language that was originally finalized in "Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004" final rule with comment period (68 FR 67963) but then inadvertently omitted again when § 414.610(c)(5) was later republished, so that § 414.610(c)(5)(i) correctly sets forth the statutory time period during which this rural mileage bonus was applicable. This revision to the regulation is a technical correction to conform the regulation to the statute. For further information, see program instruction, Transmittal AB-03-110; Date August 1, 2003; Change Request 2767 which was issued to inform contractors to discontinue paying such bonuses effective January 1, 2004 in accordance with the statute.

M. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 Federal Register, we published the "Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services" proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23. 2001 Federal Register (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) included the requirement that "[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary." In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000

proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that "[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered." In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: "Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record." (Transmittal AB-02-030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, "Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB-02-030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services." In the manual instructions in that transmittal in a note, we stated: "No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services." The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the Federal Register (that no

signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term "order" instead of "requisition," which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, "No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services." Based on further review, we have determined that there are no clinical laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we are restating and seeking public comments on our policy. We may further clarify our policy in the final rule, taking into consideration public comments. Our policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule; however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services. The policy that signatures are not required on requisitions applies to requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test

must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the Clinical Laboratory Fee Schedule is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic lab tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices. Because of the confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we invite the general public to comment on this policy and its impacts on operations.

We also are restating and seeking public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the clinical laboratory fee schedule and those that are not paid under the clinical laboratory fee schedule (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the Clinical Laboratory Fee Schedule applies only to requisitions (as opposed to written orders)." While there may be additional questions about the policy for physician pathology servicess, we are not addressing these issues in rulemaking at this time.

Additionally, we welcome comments from the public about the distinction between an order and a requisition. We note that an "order" as defined in our IOM, 100–02, Chapter 15, Section 80.6.1 is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a

beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

• A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.

• A telephone call by the treating physician/practitioner or his or her office to the testing facility; or

• An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/ practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

of the beneficiary's medical records. A "requisition", conversely, as we understand it, is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents; although a requisition that is signed may serve as an order. We welcome comments from the public about the distinction between requisitions and orders.

N. Physician Self-Referral

1. General Background

Section 1877 of the Act, also known as the physician self-referral law, prohibits the following: (1) A physician from making referrals for certain designated health services ("DHS") payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship (an ownership/investment interest or a compensation arrangement), unless an exception applies; and (2) The entity from presenting or causing a claim to be

presented to Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

Determining whether an entity furnishing DHS and a physician have a direct or indirect compensation arrangement is a key step in applying the statute because it affects which compensation exceptions may apply to the arrangement. Section 411.354(c) governs when a physician "stands in the shoes" of his or her physician organization and may therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing DHS.

Our proposal seeks to clarify one aspect of the physician stand in the shoes provisions at § 411.354(c). Specifically, we are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, "[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated "between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians)." A detailed discussion of this proposed clarification may be found in section II.N.2.b. of this proposed rule.

2. Physician Stand in the Shoes

a. Background

One of the first significant physician stand in the shoes provisions was finalized in the "Medicare Program; Physicians' Referrals to Health Care **Entities With Which They Have** Financial Relationships (Phase II)," interim final rule with comment period published in the March 26, 2004 Federal Register (69 FR 16054) ("Phase II"). In Phase II, we revised the definition of "referring physician" at § 411.351 to clarify that a referring physician is treated as "standing in the shoes" of his or her professional corporation (69 FR 16058, 16060). Our revision to the definition of "referring physician" clarified that it was not necessary to treat a referring physician as separate from his or her whollyowned professional corporation. We noted that the revised regulations should make it simpler for physicians and others to evaluate their financial relationships and to apply exceptions

under section 1877 of the Act. We also solicited comments on whether to permit a physician to stand in the shoes of a group practice of which he or she is a member (69 FR 16060).

We addressed certain provisions of section 1877 of the Act, including provisions relating to direct and indirect compensation arrangements, in the "Medicare Program; Physicians" Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III)," final rule published in the September 5, 2007 Federal Register (72 FR 51012) ("Phase III"). Phase III extended the Phase II rule that treated referring physicians as standing in the shoes of their whollyowned professional corporations only (72 FR 51026). Specifically, we amended § 411.354(c) to add a provision under which all referring physicians will be treated as "standing in the shoes" of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements in § 411.354 (72 FR 51026 through 51029). Phase III defined a "physician organization" at § 411.351 to be "a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352." Under Phase III, when determining whether a direct or indirect compensation arrangement existed between a physician and an entity to which the physician refers Medicare patients for DHS, the referring physician would stand in the shoes of: (1) Another physician who employs the referring physician; (2) his or her wholly-owned professional corporation; (3) a physician practice (that is, a medical practice) that employs or contracts with the referring physician; or (4) a group practice of which the referring physician is a member or independent contractor. We specified in § 411.354(c)(3)(i) that a physician who stands in the shoes of his or her physician organization would be considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands. In addition, we specified in the second sentence of § 411.354(c)(3)(i) that "[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization

(including all members, employees, or independent contractor physicians)."

The Phase III stand in the shoes rules were made in an effort to address two issues. First, industry representatives had asserted that resorting to the indirect compensation definition and exception added an unnecessary step when determining compliance with the physician self-referral prohibition. These representatives believed that it would be easier, more efficient, and consistent with the intent of the physician self-referral law to examine the relationship between the hospital and the group practice for compliance with a physician self-referral exception. The representatives urged that a referring physician should stand in the shoes of his or her group practice, which acts on behalf of its physician members and contractors. Depending on the circumstances, this would enable the parties to analyze the arrangement between the entity furnishing DHS and the group practice (for example, a lease of office space, a personal service arrangement, or a fair market value compensation arrangement) to determine its compliance with one of the various direct compensation arrangement exceptions, rather than the indirect compensation arrangements exception at § 411.357(p). We agreed and permitted a physician to stand in the shoes of his or her group practice, thereby permitting physicians and entities furnishing DHS to use a direct compensation arrangement exception in some circumstances.

Second, we were informed that parties may have construed the definition of an indirect compensation arrangement too narrowly, resulting in erroneous determinations that some arrangements involving financial incentives for referring physicians would fall outside the ambit of the physician self-referral law. In particular, we were concerned that some arrangements between entities furnishing DHS and group practices were viewed as outside the application of the statute. The stand in the shoes provisions set forth in Phase III were designed to address this concern by treating compensation arrangements between entities furnishing DHS and group practices as if the arrangements were with the group's referring physicians.

In response to concerns raised by some industry representatives, we published a final rule in the November 15, 2007 **Federal Register** (72 FR 64161) delaying the date of applicability of the Phase III stand in the shoes provisions with respect to certain compensation arrangements involving physician

organizations and academic medical centers or certain integrated 501(c)(3) health care systems, from December 4, 2007 until December 4, 2008.

We finalized revisions to § 411.354(c)(1)(ii) to deem (so as to require) a physician who has an ownership or investment interest in a physician organization to stand in the shoes of that physician organization in the "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical **Education in Certain Emergency** Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals" final rule ("FY 2009 IPPS final rule") published in the August 19, 2008 Federal Register (73 FR 48434). Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment) are not deemed to stand in the shoes of their physician organizations. We also added § 411.354(c)(1)(iii) to permit (but not require) a titular owner and a physician who does not have an ownership or investment interest in a physician organization to stand in the shoes of his or her physician organization. This rule became effective October 1, 2008.

b. Proposed Clarification to § 411.354(c)—Applying Exceptions in § 411.355 and § 411.357 to Arrangements in Which a Physician Stands in the Shoes of His or Her Physician Organization

Section 411.354(c)(3)(i) addresses the application of the general exceptions to the referral prohibition related to both ownership/investment and compensation (§ 411.355) and the exceptions to the referral prohibition related to compensation arrangements (§ 411.357), to arrangements in which a physician stands in the shoes of his or her physician organization. Many of these exceptions require the arrangement to be in writing and signed by the parties and prohibit the compensation from taking into account the volume or value of referrals or other business generated by the referring physician.

Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her

physician organization is deemed to have the same compensation arrangements with the same parties and on the same terms as the physician organization. The second sentence of § 411.354(c)(3)(i) provides that "[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians)."

After the publication of Phase III, some members of the industry questioned whether the second sentence of § 411.354(c)(3)(i) defined the term "parties" everywhere it appears in the physician self-referral regulations, including the requirement in many exceptions that a compensation arrangement be in writing and "signed by the parties." Specifically, these members believed it was necessary for everyone within a physician organization (that is, all members, employees, and independent contractor physicians) to sign a myriad of different arrangements with an entity furnishing DHS. This was not our intent. In January 2008, we posted a frequently asked question (FAQ) on our Web site to address this issue (see question #8885 at https://questions.cms.hhs.gov/cgi-bin/ cmshhs.cfg/php/enduser/ std adp.php?p faqid=8885.) In the FAQ, we explained that a physician who stands in the shoes of his or her physician organization need not become a signatory to a written agreement between the physician organization and an entity furnishing DHS because "we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement." After the FY 2009 IPPS final rule, under which only physician owners are deemed to stand in the shoes of their physician organizations, some industry representatives questioned whether physicians who did not stand in the shoes remained "parties" under § 411.354(c)(3)(i) and would therefore need to become signatories to any compensation arrangement that was required to be in writing and "signed by the parties.'

We are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, "[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business

generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians)." We believe this proposed language clarifies the regulation text and is consistent with our intent to minimize the potential for abuse without imposing undue burden on the provider community.

Our proposed change clarifies that we are not defining the term "parties" and should eliminate any possible public misconception that all physicians in a physician organization (whether or not they stand in the shoes of the physician organization) must sign the writing(s) memorializing a compensation arrangement between their physician organization and an entity furnishing DHS. Furthermore, we note that some members of the industry have erroneously applied the second sentence of § 411.354(c)(3)(i) by analyzing whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization only, not the referrals of all members, employees, and independent contractor physicians in the physician organization. As we indicated in the Phase III final rule (72) FR at 51028), the second sentence of § 411.354(c)(3)(i) was intended to require (where applicable) an analysis of whether a compensation arrangement takes into account referrals or other business generated by the physician organization as a whole and not merely referrals or other business generated by the physicians who stand in its shoes. Thus, we reiterate that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization (including all members, employees, and independent contractors), not simply the referrals made by each physician who stands in the shoes of the physician organization.

We welcome public comments regarding alternative approaches to address this issue.

- O. Durable Medical Equipment-Related Issues
- 1. Damages to Suppliers Awarded a Contract under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP). On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the competitive bidding program, including adding a new subsection (a)(1)(D) to section 1847 of the Act. Section 1847(a)(1)(D) terminates retroactively the competitive bidding contracts that were awarded to suppliers in 2008 for the Round 1 of competitive bidding and prohibits payment based on such contracts. Section 154 of the MIPPA effectively reinstated payment for competitively bid items and services to the Medicare fee schedule amounts, as set forth in section 1834 of the Act and 42 CFR part 414, subpart D of our regulations.

Section 1847(a)(1)(D)(i)(I) of the Act, as amended by the MIPPA, stipulates that to the extent any damages may be applicable as a result of the termination of contracts, payment is to be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act. Section 1847(a)(1)(D) of the Act also states that nothing in section 1847(a)(1)(D)(i)(I) of the Act, which includes the reference to damages, shall be construed to provide an independent cause of action or right to administrative or judicial review with the regard to the termination of the Round 1 contracts.

For further discussion of the Competitive Bidding Program and the bid evaluation process, see the Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues final rule published in the April 10, 2007 Federal Register (72 FR 17992) and the Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) interim final rule with comment period (IFC)

published on January 16, 2009 **Federal Register** (74 FR 2873).

In this proposed rule, we are proposing to add new § 414.425 to establish a process to evaluate any claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

We offered contracts in March of 2008 to selected suppliers for the first round of the DMEPOS CBP. The contracts that were accepted were terminated by the MIPPA retroactive to June 30, 2008. We considered the terms of the contracts and other processes of the DMEPOS CBP as we developed this proposed process to determine, on a case-by-case basis, whether to award damages and, where applicable, the amount of damages to be awarded for the termination of these contracts.

When considering whether to submit a claim for damages, suppliers may consider the following factors:

- Each contract stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program.
- Each contract indicated CMS does not guarantee any amount of business or profits.
- Each contract stipulated that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized under the contract.
- Upon termination of the contracts by the MIPPA, payments reverted to the CY 2008 fee schedule amount, which was on average 26 percent higher than payment amounts under the DMEPOS CBP.
- We will review a supplier's estimated and historic capacity and any expansion plans that were submitted as part of a supplier's bid.

• We will review a supplier's action to meet its obligation to mitigate its damages.

 We listed the winning suppliers on the Medicare.gov Web site in the supplier locator tool; a supplier is allowed to keep any new customers they may have obtained because of being listed on the supplier locator tool.

• This list is not intended to suggest that there are not legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

The provisions of this proposed rule outline the information that we are proposing suppliers provide when submitting claims for damages and the process that we will follow to review these claims. The information we propose to collect from suppliers is necessary for us to make a reasonable decision on whether damages are warranted and how much in damages should be awarded. We believe the process is not overly burdensome to those suppliers choosing to participate in this review process and will ensure a thorough review of a supplier's claim for damages.

The proposed process to file a claim for damage claims includes the following provisions:

a. Eligibility To File a Claim

Any aggrieved supplier that was awarded a contract in 2008 for the Round 1 DMEPOS CBP and believes it has suffered damages is eligible to submit a claim. The supplier must be able to demonstrate how its company was damaged. These damages must be substantiated and be as a direct result of the termination by MIPPA of their Round I DMEPOS CBP contract. Only a contract supplier, and not a subcontractor of a contract supplier, is eligible to submit a claim for damages.

b. Timeframes for Filing a Claim

A completed claim, including all documentation described below in section II.O.1.c., must be filed within 90 days of the effective date of the finalization of these damages provisions, unless the 90th day is a weekend or Federal holiday. In that case, the last date to file a claim will be the day following the weekend or Federal holiday. The date of filing is the actual date of receipt by the CBIC of a completed claim from the supplier that includes all of the information required by this rule. We strongly urge claimants to use a tracking method such as with the United States Postal Service or a carrier that requires a return receipt that indicates the date on which the claim was delivered.

c. Information That Must Be Included in a Claim

At a minimum, a claim should include all of the following:

- Supplier's name and bidding number.
- Supplier's current contact information (Name of authorized official, U.S. Post Office mailing address, phone number and e-mail address).
- A copy of the DMEPOS CBP Round I contract(s) the supplier signed with CMS
- A detailed explanation of the damages incurred by the supplier. The explanation must document the supplier's damages through receipts and records that establish the claimant's

damages directly related to meeting the terms of the DMEPOS CBP Round I contract.

- The supplier must also explain how it would be damaged if not reimbursed.
- A detailed explanation of the steps of all attempts to use for other purposes, return, or dispose of equipment or other assets purchased or rented for use in the Round I DMEPOS CBP contract performance.

Damages claimed must be specifically related to carrying out the terms of the contract, and may include, but are not limited to, the following:

- Items or equipment purchased or rented.
 - Additional employee costs.
 - Additional inventory costs.
 - Additional facility costs.

The supplier must include a separate justification for any of these items for which it is claiming damages and explain how they were necessary in terms of meeting the requirements of the Round 1 DMEPOS CBP contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. The claim must also detail steps taken by the supplier to mitigate damages that they may have incurred due to the contract termination.

d. Items That Will Not Be Considered in a Claim

CMS will not award damages for the following:

- Cost of submitting a bid.
- Cost of preparing or submitting a claim for damages under this section.
- Fees or costs incurred for consulting or marketing.
 - Cost of accreditation or licensure.
- Costs incurred before March 20, 2008.
- Costs incurred after July 14, 2008 except for costs incurred to mitigate damages.
- Any profits a supplier may have expected from performance of the contract.
- Costs that would have occurred without the supplier having been awarded a contract.
- Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.
- Costs already recouped by use of personnel, material, supplies, or equipment in the supplier's business operations.

We are not considering claims for expenses incurred prior to March 20, 2008 including the purchase or rental of items or equipment before that date, because a supplier would not have known that it was going to be offered a contract. We are not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts.

e. Filing a Claim

Suppliers should submit claims, with all supporting documentation, with the CMS Competitive Bidding Implementation Contractor (CBIC) at the following address: CBIC; Bldg 200, Suite 400; 2743 Perimeter Parkway; Augusta, Georgia 30909. The authorized official for the supplier must certify the accuracy of the information on the claim and all supporting documentation. The authorized official is appointed by the supplier and has the legal authority granted by the supplier to submit the claim for damages. This person may be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of the supplier organization, or must hold a position of similar status and authority within the supplier's organization. The CBIC will not accept electronic submissions of claims for damages.

f. Review of Claim

(1) Role of the CBIC

The CBIC will conduct the first level of review and make recommendations to CMS, hereafter referred to as the Determining Authority regarding:

- Whether the claim is complete and was filed in a timely manner. The CBIC may seek further information from the claimant when making its recommendation. The CBIC may set a deadline for receipt of additional information.
- When the claim is incomplete or was not filed in a timely manner, the CBIC will make a recommendation to the Determining Authority not to process the claim further.
- Whether the government owes damages because of the MIPPA. The CBIC will include an explanation supporting its recommendation. The CBIC will recommend a reasonable amount of damages, if any, based on the claim submitted, including all accompanying documentation. The CBIC will consider the language of the contract, as well as both costs incurred and the contract supplier's attempts and actions to limit the damages.

(2) CMS' Role as the Determining Authority

CMS is the Determining Authority because we are responsible for the final review and final determination regarding claims for damages.

- The Determining Authority shall review the recommendation of the CBIC.
- The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.
- The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.
- If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the determination and the reasons for the final determination.
- If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may:
- + Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety; or direct the CBIC to write said determination for the Determining Authority's signature.
- + Return the claim to the CBIC with further instructions.
- The Determining Authority's determination is final and binding; it is not subject to administrative or judicial review under section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1) of the MIPPA.

g. Timeframe for Final Determinations

Every effort will be made to make a final determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later. In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

h. Notification to Claimant of Damage Determination

The CBIC shall mail the final determination to the claimant by certified mail return receipt requested. If CMS determines that money is due to a claimant, this notification will indicate when and how the money will be transmitted. If a monetary award is due, the supplier will be required to provide banking information for electronic deposit.

2. Notification to Beneficiaries for Suppliers Regarding Grandfathering

Section 1847(a)(4) of the Act requires that in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary shall establish a "grandfathering" process under which rented DME items that were furnished prior to the start of the Competitive Bidding Program (CBP) may be continued to be rented to the beneficiary by a noncontract supplier. Agreements for those covered items and supplies that were rented by the supplier to the beneficiary before the start of a CBP may be continued, regardless of whether the existing supplier participates in the CBP.

In the April 10, 2007 final rule (72 FR 17992), in § 414.408(j), we established the grandfathering process described below for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS CBP. A supplier that is furnishing DME or is furnishing oxygen or oxygen equipment on a rental basis to a beneficiary prior to the implementation of a CBP in the competitive bidding area (CBA) where the beneficiary maintains a permanent residence may elect to continue furnishing the item as a grandfathered supplier. This process only applies to suppliers that began furnishing the competitive bid items described above before the start of the CBP to beneficiaries who maintain a permanent residence in a CBA.

In the case of the rented DME and oxygen and oxygen equipment identified in this section, we established in § 414.408(j)(4) that Medicare beneficiaries have the choice of deciding whether they would like to continue receiving the rented item from a grandfathered supplier or if they would like to receive the item from a contract supplier.

Suppliers that agree to be a grandfathered supplier for an item must agree to be a grandfathered supplier for all current beneficiaries who request to continue to rent that item from them. The beneficiary's decision to use a grandfathered supplier depends on the decision of the noncontract supplier that is currently renting the competitive bidding item to continue renting the item as a grandfathered supplier after the start of the CBP in accordance with the terms we have specified. The payment rules for grandfathered suppliers are specified in existing § 414.408(j)(2).

In addition, the beneficiary may elect, at any time, to transition from a noncontract supplier to a contract supplier. The contract supplier would be required to accept the beneficiary as a customer regardless of how many rental months had already been paid for the beneficiary to receive this item. If the grandfathered supplier is not willing to continue furnishing the item, a beneficiary must select a contract supplier to furnish the item in order to receive Medicare payment for that item. The grandfathered supplier is paid based on the payment rules outlined in the final rule on Competitive Bidding at § 414.408(j).

As a result of what we learned from Round 1 of the CBP, we are proposing changes to the "grandfathering" rules by establishing notification requirements for noncontract suppliers that are furnishing rented DME competitive bid items at the time a CBP begins to beneficiaries residing in a CBA. We are also proposing a new definition for a grandfathered item to include all rented item(s) in a competitive bidding product category that a supplier currently provides to its beneficiaries. Under the current regulation, suppliers may choose the items within a product category for which they want to become a grandfathered supplier. Under this proposed rule, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the rented DME items within a product category that the supplier currently provides.

For further discussion of the CBP and the bid evaluation process, *see* the April 10, 2007 final rule and the January 16, 2009 interim final rule with comment

We are proposing to revise the definition of "grandfathered item" in § 414.402 so that the term would refer to all rented items within a competitive bid product category that the supplier currently rents to beneficiaries. In addition, we are proposing to redesignate the current § 414.408(j)(5) as § 414.408(j)(7) and add new § 414.408(j)(5)and (j)(6). The new § 414.408(j)(5)and (j)(6) will specify the notification requirements that apply to noncontract suppliers that are renting DME competitive bid items in a CBA at the time of implementation of the CBP.

a. Definition of a Grandfathered Item

We are proposing to revise the definition of a "grandfathered item" in § 414.402 to avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the

current regulations, a supplier may make separate choices regarding grandfathering for each individual HCPCS code. For example, a supplier may choose to be a grandfathered supplier for a particular type of walker within the product category instead of all of the walkers included in that product category that are furnished on rental basis.

Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code. In addition, this proposed revision would prevent suppliers from choosing to be a grandfathered supplier for only the more profitable items, which could disadvantage certain beneficiaries.

b. Notification of Beneficiaries and CMS by Suppliers That Choose To Become Grandfathered Suppliers

We are proposing to add a new § 414.408(j)(5) to require suppliers furnishing items to be included in a CBP that are eligible for grandfathering to notify beneficiaries in the CBA and CMS regarding their decision whether to become grandfathered suppliers.

The notification requirements we are proposing will prohibit certain inappropriate practices of noncontract suppliers. These inappropriate practices include: (1) Suppliers attempting to receive additional monthly rental payments from Medicare by circumventing the grandfathering requirements; and (2) suppliers not formally notifying beneficiaries before picking up the rented item from the beneficiary's home. We are also proposing to require a notification process to protect beneficiaries and to ensure less confusion during the transition period prior to implementation of the CBP. The proposed requirements will help ensure that beneficiaries are contacted and informed about the grandfathering process and what choices they have concerning their choice of supplier. Moreover, the notice will help to ensure that beneficiaries do not have medically necessary DME equipment taken from them unexpectedly by a noncontract supplier.

(1) Notification of Beneficiaries by Suppliers That Choose to Become Grandfathered Suppliers

We are proposing to add § 414.408(j)(5)(i) which requires a noncontract supplier that elects to become a grandfathered supplier in a CBA to provide a written notification to each Medicare beneficiary in that CBA who is currently renting a grandfathered item from that supplier. The notification must state that the supplier is willing to continue to rent the grandfathered item(s) to the beneficiary as a grandfathered supplier. The notice must identify the DME grandfathered rented items for which the supplier will be a grandfathered supplier.

To ensure that beneficiaries are sufficiently informed and prepared for competitive bidding changes that affect rented DME, we are proposing in § 414.408(j)(5) to require that the notification of the beneficiary must meet the following requirements. The notification must:

- Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the CBP in the CBA in which the beneficiary resides. The 30-day notice is necessary to give the beneficiary sufficient time before the start of the CBP to consider whether to continue to use their current supplier. Suppliers will be given sufficient time to meet the 30-day notification requirement.
- Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.
- Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.
- State that the supplier is offering to continue to furnish certain rented DME, oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the CBP) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.
- Provide the supplier's telephone number and instruct the beneficiaries to call the supplier with questions regarding grandfathering and to notify the supplier of his or her election.
- State that the beneficiary can obtain information about the CBP by calling

1–800–MEDICARE or accessing http://www.medicare.gov on the Internet.

In § 414.408(j)(i)(B), we propose that the supplier should obtain an election from the beneficiary and maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. We are also proposing that the supplier maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 30-day notice to the beneficiary must be in writing to ensure that there is a record that the notification was made.

We are proposing to add paragraphs § 414.408(j)(5)(i)(C)(1) through (3) which state if the beneficiary chooses not to continue to receive a grandfathered item(s) from the noncontract supplier, the supplier must provide the beneficiary with 2 additional notices prior to picking up its equipment. These notices are described below as the 10-Day Notification and the 2-Day Notification.

(i) 10-Day Notification

Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up and that this should occur on the first anniversary date after the start of the CBP or another date agreed to by the beneficiary. The noncontract supplier must bill and will be paid for the furnishing of the equipment up to the first anniversary date after the start of the CBP and the new supplier cannot bill for furnishing the equipment prior to this anniversary date. This requirement still applies if a date other than the anniversary date is chosen.

The beneficiary's anniversary date occurs every month on the date of the month on which the item was first delivered to the beneficiary by the current supplier. The anniversary date marks the date of every month on which a new monthly rental period begins. For example, using July 1 as the beginning date of the Medicare DMEPOS CBP:

• If a beneficiary's last anniversary date before the beginning of the CBP is June 29, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28. The noncontract supplier should not pick up the equipment prior to July 29. In this case, the noncontract supplier has been paid up to July 29 and therefore should pick up its equipment on July 29, and the contract supplier

would deliver its equipment on July 29 and begin billing for the next month's rental as of that date.

• If a beneficiary's anniversary date is July 1, also the beginning date for the CBP, the noncontract supplier should not pick up the equipment before July 1 and should not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1 and submit a claim for this month.

When a DME supplier submits a monthly bill for capped rental DME items, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.). In cases where the anniversary date falls at the end of the month (for example, January 31) and a subsequent month does not have a day with the same date (for example, February), the final date in the calendar month (for example, February 28) will be used.

(ii) 2-Day Notification

Two business days prior to picking up the item, the supplier must contact the beneficiary by phone to remind the beneficiary of the date the supplier will pick up the item. This supplier should not pick up the item before the beneficiary's first anniversary date that occurs after the start of the CBP.

There may be unusual circumstances that make it difficult to contact certain beneficiaries. However, we do not expect this to occur often because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries. Therefore, the supplier should have an ongoing relationship with the beneficiary and be aware of how to contact them and any changes in their circumstances. However, under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that they are aware of the date on which the supplier is picking up the item and that arrangements have been made to have the item replaced on that date by a contract supplier. The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date. The pick up by the noncontract supplier and the delivery by the contract supplier should occur on the first rental anniversary date of the equipment that occurs after the start of the CBP. When a beneficiary chooses to switch to a new contract supplier, the

current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, for the pickup and the delivery date but not in terms of billing. The new equipment cannot be billed for until the anniversary date and the old equipment cannot be taken from the beneficiary before the anniversary date.

c. Notification to CMS for Suppliers That Choose To Become Grandfathered

We are proposing to add § 414.408(j)(5)(ii) to state that suppliers that have chosen to become grandfathered suppliers must also notify CMS of that decision at least 30 business days before the start of the CBP. We believe that 30 business days is a reasonable period to allow us to compile a list of grandfathered suppliers and to answer questions about the availability of these suppliers. Unless the supplier notifies CMS consistent with this subsection, the supplier will not be considered a grandfathered supplier. Having a list of grandfathered suppliers is important to assist CMS in administering the grandfathering process. The list will be used to answer questions from beneficiaries concerning which suppliers have chosen the grandfathering option. The notification requirement will also help us to ensure that suppliers are not offering the grandfathering option to only a select number of beneficiaries. Also, having a list of suppliers that have chosen to be grandfathered suppliers will assist us in reviewing whether only noncontract suppliers that have elected to be grandfathered suppliers have received Medicare payment for rented competitive bid items in a CBA.

The notice that a noncontract supplier must provide to CMS if it elects to become a grandfathered supplier must meet the following requirements:

- State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the CBP) in a CBA and will continue to provide these grandfathered items to these beneficiaries for the remaining months of the rental period.
- Include all of the following: Name and address of the supplier; 6-digit NSC number of the supplier; and product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.
- Suppliers with multiple locations must submit one notification for the company rather than for each individual location.

- State that the supplier agrees to meet all the terms and conditions applicable to grandfathered suppliers.
- Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of a CBP.
- d. Notifications of Beneficiaries by Suppliers That Choose Not To Become Grandfathered Suppliers

We propose to clarify under § 414.408(j)(6) that a noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notice to the beneficiary. A noncontract supplier that decides not to become a grandfathered supplier does not have the option of leaving its equipment in the beneficiary's home. The noncontract supplier is responsible for picking up the item from the beneficiary.

Proper notification by a supplier who chooses not to become a grandfathered supplier must include a 30-day, a 10-day, and a 2-day notice of its decision not to be a grandfathered supplier.

These notifications must meet all of the requirements listed above for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, except for the following differences for the 30-day notice.

- The 30-day notice must indicate the items for which the supplier has decided not to become a grandfathered supplier and indicate the date upon which the equipment will be picked up.
- It must state that the supplier will only continue to rent these competitively bid item(s) up to the beneficiary's first anniversary date, as defined in § 414.408(j)(5), that occurs after the start of the Medicare DMEPOS CRP
- It must also state that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.
- It must state that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing http://www.medicare.gov on the Internet.
- It must also refer him or her to the supplier locator tool on http://www.medicare.gov.

The supplier must also provide the beneficiary with the 10-day and the 2day notices prior to picking up their equipment.

When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, but the new equipment may not be billed by the contract supplier until the first anniversary date following the start of the CBP. Also, the old equipment may not be taken from the beneficiary before proper arrangements are made and the date of service cannot occur before the anniversary date.

As discussed above, under no circumstance should a supplier pick up the rented item prior to the supplier making an arrangement with the new contract supplier for the delivery of the new equipment at a time suitable to meet the beneficiary's medical needs. The noncontract supplier has been furnishing services to the beneficiary and receiving payments from the program. To ensure that the beneficiary has continued access to medically necessary equipment, the noncontract supplier is expected to assist the beneficiary in locating a contract supplier. The noncontract supplier should communicate with the beneficiary the urgency of arranging to have the new equipment delivered as soon as possible.

P. Physician Fee Schedule Update for CY 2010

Since 1999, PFS rates have been updated under the sustainable growth rate (SGR) system. The general concept under the SGR system is that growth in total expenditures for physicians' services should be limited to sustainable levels. If expenditures exceed a statutorily determined percentage increase amount, the PFS update for the following year is reduced. If expenditures are less than the percentage increase amount, the PFS update is increased in the following year. There is a recognized tendency for physicians to increase the volume and intensity of their services over time. Incentives under SGR system were intended to encourage physicians to regulate their collective behavior in that regard in order to avoid decreases in future updates. The SGR is also a cumulative system. The update is adjusted based on a comparison of cumulative actual spending to target spending from a base period through the current year. Thus, if spending exceeds the target in a single year, the following year's update must be adjusted to reduce annual expenditures, as well as recoup the difference between target and actual spending in the prior year. Under a cumulative system, deviations between target and actual spending have the potential to result in significantly more payment rate adjustments when actual spending exceeds target spending

even in a single year. ²⁰ Further, under a cumulative system, past increases in spending levels above the target will continue to affect future PFS updates until there have been sufficient adjustments to make target and actual spending equal.

Despite the intended incentives, actual spending under the SGR system has deviated significantly from target spending. In the CY 2004 PFS final rule with comment period (68 FR 63248), we estimated CY 2003 allowed expenditures at \$71.7 billion and CY 2003 actual expenditures at \$77.8 billion for a difference of \$6.1 billion (or 8.5 percent of allowed spending). The cumulative difference between target and actual expenditures estimated at the time was \$7.8 billion (that is, the \$6.1 billion plus an additional \$1.7 billion for past differences between target and actual spending since the 1996/1997 base year not previously accounted for through adjustments to the PFS update). Under the statutory formula, CMS was required to announce a reduction in PFS rates of 4.5 percent for CY 2004:

[T]he negative physician fee schedule update gives us no alternative to reducing physician fee schedule rates. Only Congress can change the law and avert a reduction in 2004 physician fee schedule rates. (68 FR 63239)

On November 25, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173). The President signed the MMA into law on December 8, 2003. Section 601 of MMA amended section 1848(d) of the Act to specify that the update to the single conversion factor (CF) for CYs 2004 and 2005 shall not be less than 1.5 percent. Thus, instead of applying an update of -4.5 percent in 2004, we applied an increase of 1.5 percent to PFS rates. The Congress took similar actions to avert reductions to PFS rates for CYs 2006 through 2009. Because the legislation did not affect the computation of the levels of allowed and actual expenditures for these years, there is now a substantial difference between cumulative target and actual spending that must be accounted for through future reductions to PFS rates. In a March 1, 2009 letter from CMS to the MedPAC, we estimated the difference between cumulative target and actual spending from the 1996/1997 base year through December 2009 at \$69.7 billion. We estimated the PFS update would be

²⁰ The adjustments to equate allowed and actual spending do not occur in a single year. The Balanced Budget Refinement Act of 1999 specifies a formula that makes the adjustment to account for differences between target and actual spending over multiple years.

-21.5 percent for CY 2010. As there are limits to how much PFS rates can be reduced in a single year and the estimated -21.5 percent PFS update will not fully account for the difference between target and actual spending, we are estimating further reductions of between 5 and 6.5 percent for the next several years.

Although the Congress has acted to avert reductions in the past several years, these projections have led us to reexamine administrative actions that the Secretary could take to lessen the potential for repeated further reductions in the PFS update. The Administration believes that the current Medicare physician payment system, while having served to limit spending to a degree, needs to be reformed to give physicians appropriate incentives to improve the quality and efficiency of the care provided to Medicare beneficiaries. As part of health care reform, the Administration supports comprehensive, but fiscally responsible, reforms to the physician payment formula. Consistent with this goal, the Administration announced in the FY 2010 President's Budget that it would explore the breadth of options available under current authority to facilitate such reforms, including an assessment of whether the cost of physicianadministered drugs should continue to be included in the payment formula.

The statutory formula for calculating the update adjustment factor, which includes the SGR, was designed to establish reasonable limits on the growth of expenditures on physicians' services, and to provide incentives for physicians to keep the growth in expenditures within those limits. The SGR system was created by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33). It replaced the predecessor system, the Medicare Volume Performance System (MVPS). However, the statutory definition of "physicians' services" for purposes of the SGR (section 1848(f)(4)(A) of the Act) is the same as that used for the MVPS (no longer in existence, but previously at section 1848(f)(5)(A) of the Act):

The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or in a physician's office.

Under the MVPS, we defined "physicians' services" to include physician-administered drugs. Therefore, we adopted the same regulatory definition at the outset of the SGR system:

Because the scope of physicians' services covered by the SGR is the same as the scope of services that was covered by the Medicare volume performance standards, we are using the same definition of physicians' services for the SGR in this notice as we did for the Medicare volume performance standards.

* * * (63 FR 59188)

Physician-administered drugs are covered under section 1861(s)(2)(A) of the Act as "services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional services, of kinds which are commonly furnished in physicians' offices." Physicianadministered drugs are not paid for under the PFS (56 FR 25800). However, in identifying items and services to be included in the definition of "physicians' services" our "practice has been to make adjustments to the SGR for medical and other health services * * * that meet the criterion of being "commonly performed by a physician or in a physician's office" (66 FR 55316). Because "incident to" drugs are commonly furnished in physicians offices, we elected to continue to include them in the definition of "physicians' services" for the SGR. Similarly, clinical diagnostic laboratory tests, which are not paid for under the PFS, have always been included in the definition of "physicians' services" for purposes of the SGR.

Historically, growth in the cost of prescription drugs has far outpaced growth in the cost of other physicians' services. From the 1st quarter of 1997 through the 1st quarter of 2005, the average annual growth in Medicare spending on drugs included in the SGR was 22 percent compared to 6 percent for all services (including drugs) included in the SGR. As a result, since the inception of the SGR methodology, prescription drugs have accounted for an increasingly disproportionate amount of the growth in spending on physicians' services. At the time, we made the decision to include physicianadministered drugs in the definition of "physicians' services" used to compute the SGR, these drugs represented a much smaller volume of Medicare spending than they have in subsequent years. In the CY 2003 PFS final rule with comment period, we estimated that drugs would represent 7.3 percent of 2001 SGR spending (67 FR 80031). In the CY 2006 PFS final rule with comment period, we estimated that drugs would represent 9.9 percent of 2004 SGR spending. In the CY 2007 PFS final rule with comment period, we stated that "commenters noted that expenditures on these drugs increased

from \$1.8 billion in 1996, to \$8.6 billion in 2004" (71 FR 69755). These figures clearly demonstrate that spending on physician-administered drugs has been growing at much higher rates than spending for all other PFS services and has contributed significantly to the deviation between target and actual spending, as well as to the large projected reductions in future PFS updates. There could be many reasons for the disproportionate growth in expenditures for drugs—many of which we could not have anticipated when we decided to include drugs in the SGR. In the CY 2006 PFS final rule with comment period (70 FR 70307), we summarized public comments on the proposed rule that stated that growth in Medicare spending on drugs is driven primarily by the introduction of expensive new drugs to the Medicare population and extensive marketing (including direct-to-consumer advertising). Given the significant and disproportionate impact that the inclusion of drugs has had on the SGR system, we believe it would be appropriate to revise the definition of physicians' services for purposes of the

As previously noted, the statutory definition of "physicians' services" for purposes of determining allowed expenditures and the SGR (section 1848(f)(4)(A) of the Act) states:

The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or in a physician's office.

The statute clarifies that the term "physicians' services" includes items and services "specified by the Secretary." Therefore, we believe the statute provides the Secretary with clear discretion to decide whether physicianadministered drugs should be included or excluded from the definition of 'physicians' services." As the statute affords the Secretary clear discretion, we are proposing, in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments, to remove physician-administered drugs from the definition of "physicians' services" in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years.

Moreover, given the past effect of spending growth for physicianadministered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of "physicians' services" in section 1848(f)(4)(A) of the Act, it is reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

We note the term "actual expenditures" is not defined in the statute nor are there any statutory limitations on the Secretary's ability to recompute actual expenditures to reflect changes in the amount of actual expenditures. On several occasions, we have made revisions to the amount of actual expenditures to reflect new information regarding spending on physicians' services. For instance, in the CY 2002 PFS final rule with comment period (66 FR 55314), we indicated that a number of new procedures were inadvertently not included in the measurement of actual expenditures beginning in 1998. We determined that spending for these codes must be included in actual expenditures for historical, current, and future periods. Similarly, in the CY 2009 PFS final rule with comment period, we discovered that fifteen procedure codes were inadvertently omitted from the measurement of actual expenditures beginning in 1998 (73 FR 69902). Again, we stated that spending for these codes must be included in actual expenditures for historical, current, and future periods.

Under section 1848(d)(3)(C)(i) of the Act, the level of allowed expenditures during the base year (April 1, 1996 through March 31, 1997) is equal to the actual expenditures for this period. Thus, as there are no statutory restrictions on the Secretary's ability to recompute actual expenditures to remove the costs associated with physician-administered drugs, the Secretary also has authority to remove these drugs from the calculation of allowed expenditures during the base year. Allowed expenditures in a year are based on the allowed expenditures in the prior year, updated by the SGR as specified in section 1848(d)(3)(C)(ii) of the Act for FY 1998 through FY 2000, and section 1848(d)(4)(C)(iii) for all subsequent years. Thus, once the Secretary has revised the level of allowed expenditures during the base year (as is authorized under the statute), it is reasonable to carry this revision through into all subsequent years. As the statute affords the Secretary flexibility to remove drugs from the calculation of allowed expenditures retrospectively to the base year, we are proposing to remove drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base

year in order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates. Further, the proposal would remove drugs from the calculation of the SGR beginning with 2010.

We note that the Secretary may choose not to finalize the proposal described above or may choose to modify the proposal in the final rule, consistent with rulemaking principles, in light of new policy developments, new information, or changed circumstances.

We currently estimate that the statutory formula used to determine the physician update will result in a CY 2010 conversion factor of \$28.3208 and a PFS update of -21.5 percent. Under this proposal, removing physicianadministered drugs from allowed and actual expenditures for all prior years will not change the projected -21.5percent physician payment rate update for services furnished on or after January 1, 2010. This proposal would, however, reduce the past discrepancy between actual and target expenditures. As a result, it would reduce the number of years in which physicians are projected to experience a negative update. We note that this proposal does not mean that we are making any changes to PFS rates applicable in prior years. Rather, we are proposing to remove drugs from the calculation of allowed and actual expenditures since the 1996/1997 base year so that past year increases in drug spending would have no affect on the determination of future PFS rates.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the

affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Pulmonary Rehabilitation Program: Conditions for Coverage (§ 410.47)

Section 410.47(c) lists the components of a pulmonary rehabilitation program. Specifically, § 410.47(c)(3) through (c)(5) discuss psychosocial assessments, outcome assessments and individualized treatment plans, respectively, and the role of these tools in pulmonary rehabilitation programs. The burden associated with meeting the requirements for conducting psychosocial assessments, outcome assessments, and individualized treatment plans is the time and effort necessary for providers to document the necessary information in the patient record. While these requirements are subject to the PRA, we believe the associated burden is exempt as stated under 5 CFR 1320.3(b)(2). Psychosocial assessments, outcome assessments and individualized treatment plans are routine tools used in pulmonary rehabilitation programs and the practice of using these tools is generally recognized as an industry standard as part of usual and customary business practices.

B. ICRs Regarding Kidney Disease Education Services (§ 410.48)

Proposed § 410.48(f) states qualified persons will develop outcomes assessments designed to:

- Measure beneficiary knowledge about chronic kidney disease (CKD) and its treatment:
- Assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to CKD; and
- Assess program effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

We are proposing that the assessment will be administered to the beneficiary during one of the kidney disease education (KDE) sessions prescribed by the referring physician. The assessments will be made available to CMS upon request.

The burden associated with these requirements is the time and effort necessary to conduct an outcomes assessment, maintain record of the assessment, and to make the documentation available to CMS upon request. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that must comply with these requirements. Additionally, we are trying to determine if the use and maintenance of outcome assessments in KDE services is a standard industry business practice. Our preliminary research gathered during a CMS Open Door Forum held on November 6, 2008 and a stakeholders meeting hosted by the Agency for Healthcare Research and Quality (AHRQ) on December 16, 2008 indicates that outcome assessments are used by most but not all of the entities bound by the proposed requirements in § 410.48. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

C. ICRs Regarding Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage (§ 410.49)

Proposed § 410.49(b)(2) lists the required components of a cardiac rehabilitation program. Four of the five required components, including cardiac risk factor modification, psychosocial assessments, outcomes assessments and individualized treatment plans, impose information collection burdens. The burden associated with these requirements is the time and effort necessary to providers to customize each patient's cardiac risk modification program. Additionally, there is burden associated with conducting psychosocial assessments and outcome assessments and drafting individualized treatment plans. Although section 144(a) of the MIPPA sets forth these information collection requirements, we believe the associated information collection burden is exempt as stated under 5 CFR 1320.3(b)(2). Performing cardiac risk modification, psychosocial assessments, outcome assessments, and individualized treatment plans are routine tools used in cardiac rehabilitation programs. As stated earlier in the preamble of this proposed rule, intensive cardiac rehabilitation programs typically involve the same elements as general cardiac rehabilitation programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of cardiac rehabilitation and also may be more rigorous. The ICRs and associated burden are generally recognized as an industry standard as part of usual and customary business practices.

Proposed § 410.49(c)(1) states that to be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv). As required by § 410.49(c)(3), sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site to ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation.

The burden associated with the requirements in § 410.49(c) is the time and effort necessary for a program to demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv) and the time and effort necessary to annually submit outcomes data. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that will seek designation as intensive cardiac rehabilitation programs. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

D. ICRs Regarding Imaging Accreditation (§ 414.68)

Proposed § 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in proposed § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the proposed collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval

authority to become an accrediting organization approved by CMS.

Proposed § 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the proposed collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

Proposed § 414.68(d)(1) states that CMS or its contractor may conduct an audit of an accredited supplier, examine the results of a CMS approved accreditation organization's survey of a supplier, or observe a CMS approved accreditation organization's onsite survey of a supplier, in order to validate the CMS approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in proposed § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by its authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to file develop and file written request for reconsideration.

While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse determination or nonrenewal.

E. ICRs Regarding Payment Rules (§ 414.408)

Proposed § 414.408(j)(5) contains the notification requirements for suppliers electing to become grandfathered suppliers. Specifically, § 414.408(j)(5)(i) states that a noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the requirements as listed in § 414.408(j)(5)(i)(A) through (G).

Subsequent to the initial 30-day notice to the beneficiary, as required by § 414.408(j)(5)(ii), suppliers must also obtain and maintain a record of the beneficiary's election choice, the date the choice was made, and the manner through which the beneficiary communicated his or her choice. Additionally, § 414.408(j)(5)(iii) states that if a beneficiary chooses not to continue to receive a grandfathered item(s) from his or her current supplier, the supplier must provide the beneficiary with two more notices prior to the supplier picking up its equipment. The supplier must provide a 10-day notification and a 2-day notification. These notification requirements must meet the criteria listed in § 414.408(j)(5)(iii)(A) through (C).

Section § 414.408(j)(5)(iv) requires suppliers that elect to become grandfathered suppliers to provide a written notification to CMS of its election decision. The notification must meet the requirements as specified in § 414.408(j)(5)(iv)(A) through (D).

The burden associated with the information collection requirements contained in proposed § 414.408(j)(5) is the time and effort necessary for a noncontract supplier to make the aforementioned notifications to both beneficiaries and CMS. We estimate that 1,305 suppliers will elect to become grandfathered suppliers. Similarly, we estimate that each grandfathered supplier will need to make an average of 53 notifications based on an average of 52 beneficiaries per supplier and one notice to CMS. We estimate that it will

take 2 hours to develop the notification to the beneficiary and 2 hours to develop the notification to CMS. Similarly, we estimate that each notification will take 15 minutes to send. The total estimated burden associated with each of the 1305 suppliers complying with the requirements in proposed § 414.408(j)(5) is 17.25 hours per supplier for a total of 22,511 hours.

Proposed § 414.408(j)(6) contains the information collection requirements pertaining to suppliers that choose not to become grandfathered suppliers. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA. These notifications must meet all of the requirements listed in proposed $\S414.408(j)(5)(i)$ and (ii) for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers. However, there are exceptions regarding the 30-day notice for noncontract suppliers electing not to become grandfathered suppliers. The exceptions are listed in proposed § 414.408(j)(6)(iii)(A) through (C). In addition, suppliers must also comply with the criteria listed in proposed § 414.408(j)(6)(iv).

The burden associated with the proposed information collection requirements in § 414.408(j)(6) is the time and effort necessary for a supplier to make the required notifications to beneficiaries. We estimate that 145 suppliers will not elect to become grandfathered suppliers. Similarly, we estimate that each nongrandfathered supplier will need to make an average of 156 notifications based on an average of 52 beneficiaries per supplier. We estimate that it will take 2 hours to develop the 30-day notification to the beneficiary and 15 minutes to send out each notification. The 10-day notification will take approximately 15 minutes and the 2-day will take approximately 15 minutes. We estimate to send out all 3 notifications it will take a total of approximately 45 minutes. The total burden associated with the requirements in proposed § 414.408(j)(6) is approximately 5,945 hours.

F. ICRs Regarding Claims for Damages (§ 414.425)

Proposed § 414.425(a) states that any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP), may file a claim under this section for certain alleged damages arising out of MIPPA's termination of the Round 1 DMEPOS CBP contracts. Section 414.425(b) states that a completed claim, including all documentation, must be filed within 90 days of the effective date of the final rule on damages, unless that day is a holiday or Sunday in which case it will revert to the next business day. Section 414.425(c) lists the required documentation for submitting a claim.

The burden associated with this requirement is the time and effort necessary to gather required documentation as specified in § 414.425(c) and submit a claim for damages. This requirement is for a onetime process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their contracts by MIPPA. We awarded contracts to 329 suppliers. We expect that it will take approximately 3 hours for a supplier to gather the necessary documents and to file a claim. We anticipate that anywhere between 5 and 250 suppliers may submit a claim for damages.

While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; suppliers are submitting claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

G. ICRs Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination of Physician Participation Under Exigent Circumstances (§ 414.917)

As stated in proposed § 414.97, an approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

The burden associated with this requirement is the time and effort necessary for a CAP vendor to request a reconsideration of the termination. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The burden associated with collecting information subsequent to an administrative action is not subject to the PRA.

H. ICRs Regarding Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (§ 414.930)

As stated in the definition for a publicly transparent process for evaluating therapies in proposed § 414.930(a), a compendium must make the following materials available to the public on its Web site, coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.

(iii) A listing of all individuals (and their affiliations and sources of financial support) who have substantively participated in the development of compendia recommendations.

(iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

The definition for a publicly transparent process for identifying conflicts of interests in proposed § 414.930(a), states that a compendium must make the following materials available to the public, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This may include compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations.

(ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

The requirements in proposed § 414.930(a) constitute third-party disclosures. While third-party disclosures are subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(c)(4). Less than 10 persons or entities within a 12-month period will be required to comply.

TABLE 37—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	
§ 414.68(c)	0938-New 0938-New	3 3 1305 145	3 3 69,165 22,620	80 80 17.25 41	240 240 22,511 5,945 28,936	

If you comment on these information collection and recordkeeping requirements, please do either of the following:

- 1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or
- 2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1413–P]; *Fax:* (202) 395–6974; or *E-mail: OIRA submission@omb.eop.gov.*

Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

Part B Drug Payment

The discussion of average sales price (ASP) issues in section II.H.1 of this proposed rule does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by

manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921. A revision of the currently approved information collection request is currently under review at OMB.

Competitive Acquisition Program (CAP)

Section II.H.2. of this proposed rule discusses issues related to the competitive acquisition program for Part B drug payment. There are no new information collection requirements associated with the CAP; however, there are several previously approved information collection requests (ICR) associated with the CAP.

TABLE 38—OMB CONTROL NUMBERS

Program component	OMB control number	Expiration date	
Medicare Part B Drug and Biological CAP	0938-0954	06/30/2011	

TABLE 38—OMB CONTROL NUMBERS—Continued

Program component	OMB control number	Expiration date
Medicare Part B Drug and Biological Competitive Acquisition Program Applications ¹	0938–0955 0938–0987	08/31/2009 12/31/2011

¹An extension of the currently approved ICR is currently in the middle of the mandatory 60-day **Federal Register** notice and comment period. The ICR will be submitted to OMB for review and approval prior to the expiration date.

Physician Quality Reporting Initiative (PQRI)

Section II.G.2. of this proposed rule discusses the background of the PQRI, provides information about the measures proposed to be available to eligible professionals who choose to participate in the 2010 PQRI, and the proposed criteria for satisfactory reporting in 2010. Beginning on January 1, 2010, the Secretary is also required by section 1848(m)(3)(C) of the Act, to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the PQRI.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2010, the eligible professional must meet one of the criteria for satisfactory reporting described in sections II.G.2.e. and II.G.2.f. of this proposed rule.

For individual eligible professionals, the burden associated with the requirements of this voluntary reporting initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We believe it is difficult to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows.

We believe the burden associated with participating in PQRI has declined for those familiar with the program and who have satisfactorily participated in the 2007 PQRI and/or the 2008 PQRI. However, because we anticipate even greater participation in the 2010 PQRI, including participation by eligible professionals who are participating in PQRI for the first time in 2010, we will assign 3 hours as the amount of time needed for eligible professionals to review the list of PORI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of \$50 per hour. To account for salary increases over time, we will use an average practice labor cost of \$55 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows to be approximately \$165 per eligible professional (\$55 per hour \times 3 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Because this is a voluntary program, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI in CY 2010. Information from the "PQRI 2007 Reporting Experience Report," which is available on the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2010 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/

or measures, with the median time being 1.75 minutes. Information from the PVRP indicates that the cost associated with this burden ranges from \$0.21 in labor time to about \$10.06 in labor time for more complicated cases and/or measures, with the cost for the median practice being \$0.90.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 191.25 minutes, or 3.2 hours [(0.25 minutes per measure \times 3 measures \times 15 cases per measure) + 3 hours to 720 minutes, or 12 hours [(12 minutes per measure × 3 measures × 15 cases per measure) + 3 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from \$174.45 [(\$0.21 per measure $\times 3$ $measures \times 15$ cases per measure) +\$165] to \$617.70 [(\$10.06 per measure × 3 measures × 15 cases per measure) +

For registry-based reporting, there would be no additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on

quality measures to CMS on their behalf.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2010 would need to complete a self-nomination process in order to be considered "qualified" to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for the 2009 PQRI and did so successfully. We estimate that the proposed selfnomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2010 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours for the development of a measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience. Additionally, part of the selfnomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of \$50 per hour. Therefore, assuming the total burden hours per registry associated with the registry selfnomination process is 10 hours, we estimate the total cost to a registry associated with the registry selfnomination process to be approximately \$500 (\$50 per hour × 10 hours per

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures

that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new to PQRI for 2010 and participation in this reporting initiative is voluntary, we believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PORI through the EHR mechanism in CY 2010. The time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, 3 hours). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on PQRI quality measures should be minimal.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered "qualified" for 2010. We are unable to accurately quantify the burden associated with the EHR selfnomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate that is approximately 10 hours at \$50 per hour for a total of \$500 per EHR vendor (\$50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The time needed for an EHR vendor to review the quality measures and other information

and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with PORI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of \$50 per hour for a total burden estimate of $$2,000 ($50 per hour \times 40 hours per$ vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately 200 hours at \$50 per hour, for a total estimate of \$10,000 per vendor (\$50 per hour \times 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, we estimate that the proposed self-nomination process for the group practices for the 2010 PORI involves approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested TIN and NPI information, and provide this requested information. It is estimated that each self-nominated entity will also spend 2 hours undergoing the vetting process with CMS officials. We assume that the group practice staff involved in the group practice self-nomination process have an average practice labor cost of \$55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice selfnomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately \$220 (\$55 per hour \times 4 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been

reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods as what we have proposed, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of \$55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be \$4,565 (\$55 per hour \times 83 hours per group practice).

We invite comments on this burden analysis, including the underlying assumptions used in developing our estimates.

The Electronic Prescribing (E-Prescribing) Incentive Program

We believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program in CY 2010. Information from the "PQRI 2007 Reporting Experience Report," which is available on the PQRI section of the CMS Web site at http:// www.cms.hhs.gov/PQRI, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 E-Prescribing Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 PQRI will attempt to participate in the 2010 E-Prescribing Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2010 E-Prescribing Incentive Program.

Section II.G.5. of this proposed rule discusses the background of the E-Prescribing Incentive Program. Section II.G.5.c. of this proposed rule provides information on how we propose eligible professionals can qualify to be considered a successful e-prescriber in 2010 in order to earn an incentive payment. Similar to the PQRI, the E-Prescribing Incentive Program is a voluntary initiative. Eligible

professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful e-prescriber described in section II.G.5.c. of this proposed rule, they can qualify to receive an incentive payment for 2010.

For the 2010 E-Prescribing Incentive Program, as discussed in section II.G.5. of this proposed rule, we propose that each eligible professional would need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. Similar to PQRI, this measure would be reportable through claims-based reporting, registry-based reporting, or through EHRs, if we finalize the proposed EHR-based reporting mechanism for PQRI.

Similar to claims-based reporting for the PQRI, we estimate that the burden associated with the requirements of this new incentive program is the time and effort associated with eligible professionals determining whether the electronic prescribing quality measure applies to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. We expect the ongoing costs associated with participation in the E-Prescribing Incentive Program to decline based on an eligible professional's familiarity with and understanding of the E-Prescribing Incentive Program, experience with participating in the E-Prescribing Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the eprescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately \$55 per hour, we estimate the total cost to eligible professionals for reviewing the eprescribing measure and incorporating the use of quality data codes into the office work flows to be approximately \$55 (\$55 per hour \times 1 hour).

For claims-based reporting, the quality data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/ or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate

changes to the 837–P or CMS Form 1500 for CY 2010.

Based on our experience with the PVRP described in section II.G.5. of this proposed rule, we estimate that the time needed to perform all the steps necessary to report the e-prescribing measure to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the e-prescribing measure to be \$0.90 based on the experience with the PVRP described above.

Based on our proposed criteria for determination of whether an eligible professional is a successful e-prescriber, we estimate that each eligible professional would report the electronic prescribing measure in 25 instances during the reporting period.

Therefore, we estimate the total annual burden per eligible professional who chooses to participate in the 2010 E-Prescribing Incentive Program through claims-based reporting of the electronic prescribing measure to be 104 minutes, or 1.73 hours [(1.75 minutes per measure × 1 measure × 25 cases per measure) + 1 hour]. The total estimated cost per eligible professional to report the electronic prescribing measure is estimated to be \$77.50 [(\$0.90 per measure × 1 measure × 25 cases per measure) + \$55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registrybased reporting mechanism in CY 2010. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PORI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the registry selfnomination process.

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The time needed for an eligible professional to review the electronic prescribing measure and other information and determine whether the measure is applicable to his or her patients and the services he or she furnishes to them is

expected to be similar for EHR-based reporting and claims-based reporting (that is, 1 hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the self-

nomination process.

The burden associated with the EHRbased reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the

electronic prescribing measure is the number of times that a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claimsbased reporting of the electronic prescribing measure, we estimate the total annual burden to be 73.92 hours [(1.75 minutes per measure \times 1 measure \times 2500 cases per measure) + 1 hour]. The total estimated cost per group practice to report the electronic prescribing measure through claimsbased reporting is estimated to be \$2,305 [(\$0.90 per measure \times 1 measure \times 2500 cases per measure) + \$55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing

Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would not be a separate group practice self-nomination process for the E-Prescribing Incentive Program and, thus, no additional burden.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

IV. Response to Comments

Because of the large number of public comments we normally receive on Federal Register documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this proposed rule will redistribute more than \$100 million in 1 year. Therefore, we estimate that this rulemaking is "economically significant" as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small

businesses and other small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of \$7 million to \$34.5 million in any 1 year) (for details see the SBA's Web site at http://sba.gov/idc/groups/ public/documents/sba homepage/serv sstd tablepdf.pdf (refer to the 620000

Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of \$7 million or less based on SBA size standards.

Approximately 95 percent of physicians are considered to be small entities.

There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. We estimate that approximately 66,000 entities bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately \$10.8 billion in 2007 for which \$8.3 billion was for fee-for-service (FFS) and \$2.5 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of \$7 million to \$34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than \$34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the proposed rule has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of less than 2 percent of total revenues. There are 929 nonprofit ESRD facilities with a combined increase of 0.9 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this proposed rule complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this proposed rule has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding.

While there are 177 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 177 rural hospital-based dialysis facilities will experience an estimated 1.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately \$133 million. This proposed rule will not mandate any requirements for State, local, or Tribal governments. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section V. of this regulatory impact analysis.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this proposed rule. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work PE and MP RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2009 with proposed payment rates for CY 2010 using CY 2008 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 39. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 39 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 39

• *Specialty:* The physician specialty or type of practitioner/supplier.

• Allowed charges: Allowed charges are the Medicare Fee Schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary.) These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.

• Impact of Proposed Work RVU changes for the CY 2010 PFS.

- Impact of Proposed PE RVU changes for the CY 2010 PFS.
- Impact of Proposed MP RVU changes for the CY 2010 PFS.
- Combined Impact of all Proposed Changes. The impact shown is a combined impact that incorporates all proposed changes to Work RVUs, PE RVUs, and MP RVUs, prior to the

application of the CY 2010 negative PFS CF update under the current statute.

TABLE 39—CY 2010 TOTAL ALLOWED CHARGE IMPACT FOR WORK, PRACTICE EXPENSE, AND MALPRACTICE CHANGES*

	Specialty	Allowed charges (mil)	Impact of work RVU changes (%)	Impact of PE RVU changes** (%)	Impact of MP RVU changes (%)	Combined impact (%)
	(A)	(B)		(C)	(D)	(E)
1	TOTAL	\$77,744	0	1	0	1
2	ALLERGY/IMMUNOLOGY	. ´ 171	0	0	-2	-3
3	ANESTHESIOLOGY	1,713	0	5	1	6
4	CARDIAC SURGERY	371	-1	-1	3	-2
5	CARDIOLOGY	7,179	0	-10	-1	-11
6	COLON AND RECTAL SURGERY	129	-1	5	1	5
7	CRITICAL CARE	221	0	3	1	3
8	DERMATOLOGY	2,504	0	2	0	3
9	EMERGENCY MEDICINE	2,395	0	2	0	2
10	ENDOCRINOLOGY	370	-1	3	0	3
11	FAMILY PRACTICE	5,055	2	5	1	8
12	GASTROENTEROLOGY	1,779	-1	1	0	0
13	GENERAL PRACTICE	719	1	5	0	6
14	GENERAL SURGERY	2,213	-1	4	1	4
15	GERIATRICS	167	1	6	1	8
16	HAND SURGERY	89	-1	4	0	3
17	HEMATOLOGY/ONCOLOGY	1,888	0	-5	-1	-6
18	INFECTIOUS DISEASE	549	-1	4	1	3
19	INTERNAL MEDICINE	10,061	1	4	1	6
20	INTERVENTIONAL PAIN MANAGEMENT	352	-1	7	0	6
21	INTERVENTIONAL RADIOLOGY	227	0	- 10	0	-10
22	NEPHROLOGY	1,789	0	1	1	2
23	NEUROLOGY	1,417	-2	6	0	3
24	NEUROSURGERY	586	-1	3	1	2
25	NUCLEAR MEDICINE	72	0	- 12	-2	- 13
26	OBSTETRICS/GYNECOLOGY	615	0	1	0	1
	OPTHOREDIC CURCERY	4,736	0	11	0	11
28	ORTHOPEDIC SURGERY	3,257	0	4 3	0	3
29 30	OTOLARNGOLOGYPATHOLOGY	926 985	$\begin{bmatrix} -1 \\ 0 \end{bmatrix}$		-1 0	0
31	PEDIATRICS	64	1	4	0	4
32	PHYSICAL MEDICINE	816	0	7	0	7
33	PLASTIC SURGERY	278	-1	5	1	5
34	PSYCHIATRY	1,071	0	2		3
35	PULMONARY DISEASE	1,753	-1	3	i i i	3
36	RADIATION ONCOLOGY	1,799	Ö	_ 17	- 1	- 19
	RADIOLOGY	5,254	0	-10	- i	-11
38	RHEUMATOLOGY	494	0	0	o l	- 1
39	THORACIC SURGERY	389	-1	0	3	2
40	UROLOGY	1,989	0	-6	0	
41	VASCULAR SURGERY	685	-1	-1	0	-1
42	AUDIOLOGIST	35	0	-4	-7	-10
43	CHIROPRACTOR***	700	0	4	1	5
44	CLINICAL PSYCHOLOGIST	533	0	-7	0	-7
45	CLINICAL SOCIAL WORKER	353	0	-6	1	-6
46	NURSE ANESTHETIST	772	0	2	0	2
47	NURSE PRACTITIONER	1,004	1	5	1	7
48	OPTOMETRY	834	1	11	0	12
49	ORAL/MAXILLOFACIAL SURGERY	35	-1	3	-1	1
50	PHYSICAL/OCCUPATIONAL THERAPY	1,857	0	10	0	10
51	PHYSICIAN ASSISTANT	749	0	4	0	5
52	PODIATRY	1,656	1	7	-1	6
53	DIAGNOSTIC TESTING FACILITY	1,044	0	- 19	-5	-24
54	INDEPENDENT LABORATORY	960	0	-4	-1	-5
55	PORTABLE X-RAY SUPPLIER	85	0	-8	-2	-11

^{*}Does not include the impact of the current law CY 2010 negative update. Rows may not sum to total due to rounding.

**Note: The law caps the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50 percent to 90 percent would increase expenditures by approximately 1 percent due to a loss of savings from the OPPS cap.

**** Does not reflect the BN reduction in payments resulting from the chiropractic demonstration.

2. Resource-Based Work, PE, and MP RVUs Impacts

a. Work RVU Impacts

The work RVU impacts are almost entirely attributable to the proposed changes for consultation services. As described earlier in this proposed rule, we are proposing to no longer recognize the BILLING CODEs for consultation services so we are budget neutrally eliminating the use of all consultation codes (except for telehealth) and have allocated the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits to reflect this change.

b. PE RVUs Impacts

The PE RVU impacts are primarily attributable to the proposed incorporation of PE data from the Physician Practice Information Survey (PPIS). For a discussion of the use of this updated survey data, see section II.A.2. of this proposed rule.

For two specialties, IDTFs and Radiation Oncology, the impact of our proposed change in the utilization rate for expensive equipment is also significant. We estimate that for these two specialties, the utilization rate change will result in impacts of -2 percent and -5 percent (respectively). These impacts are included in the -19 percent and -17 percent PE RVU impacts shown in Table 39 for these specialties. After taking into account the OPPS payment cap, the change in the utilization rate for expensive equipment does not substantially reduce overall payments for other specialties.

Our proposals on consultation codes (see section II.E.4. of this proposed rule) and dominant specialty (see section II.C.2. of this proposed rule) do not have a significant impact on PE payments to specialties.

c. Malpractice RVU Impacts

The PE RVU impacts are attributable to the changes proposed for the Five-Year Review of MP RVUs described earlier in this proposed rule. Of particular note are the impacts on the specialties of Audiology (-7 percent), and IDTFs (-5 percent). These impacts are primarily driven by the expansion of the MP premium data collection and the proposed changes to the methodology for TC services.

d. Combined Impact

Column E of Table 39 displays the proposed combined impact of all RVU changes by specialty. These changes range from increases of +12 percent for optometry to decreases of -24 percent for IDTFs. The effect of our proposals on primary care specialties such as General Practice, Family Practice, Internal Medicine, and Geriatrics are positive with increases ranging from +6 percent to +8 percent. Again, these impacts are prior to the application of the negative CY 2010 CF update under the current statute.

Table 40 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2010 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, refer to Addendum A of this proposed rule.

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES

CPT 1/			Facility			Non-facility		
HCPCS	MOD	Description	2009	2010 ²	Percent change	2009	2010 ²	Percent change
11721		Debride nail, 6 or more	\$27.77	\$19.82	-29	\$40.39	32.29	-20
17000		Destruct premalg lesion	48.69	40.50	- 17	69.97	57.21	-18
27130		Total hip arthroplasty	1,359.71	1,113.00	- 18	NA	NA	NA
27244		Treat thigh fracture	1,144.39	944.21	- 17	NA	NA	NA
27447		Total knee arthroplasty	1,456.37	1,187.76	- 18	NA	NA	NA
33533		CABG, arterial, single	1,892.05	1,524.78	- 19	NA	NA	NA
35301		Rechanneling of artery	1,067.93	879.63	- 18	NA	NA	NA
43239		Upper GI endoscopy, biopsy	165.55	130.27	-21	323.16	243.84	-25
66821		After cataract laser surgery	251.38	225.15	-10	266.53	237.89	-11
66984		Cataract surg w/iol, 1 stage	638.74	568.96	- 11	NA	NA	NA
67210		Treatment of retinal lesion	561.56	502.12	- 11	580.67	517.13	-11
71010		Chest x-ray	NA	NA	NA	23.80	16.14	-32
71010	26	Chest x-ray	9.02	6.80	-25	9.02	6.80	-25
77056		Mammogram, both breasts	NA	NA	NA	107.48	80.15	-25
77056	26	Mammogram, both breasts	44.36	33.98	-23	44.36	33.98	-23
77057		Mammogram, screening	NA	NA	NA	81.51	57.49	-29
77057	26	Mammogram, screening	35.71	27.47	-23	35.71	27.47	-23
77427		Radiation tx management, x5	188.27	155.48	- 17	188.27	155.48	-17
78465	26	Heart image (3d), multiple	78.99	56.92	-28	78.99	56.92	-28
88305	26	Tissue exam by pathologist	37.15	29.45	-21	37.15	29.45	-21
90801		Psy dx interview	128.04	96.01	-25	152.92	118.95	-22
90862		Medication management	45.08	35.40	-21	55.18	45.31	- 18
90935		Hemodialysis, one evaluation	66.36	54.09	- 18	NA	NA	NA
92012		Eye exam established pat	45.80	41.35	- 10	70.69	62.87	-11
92014		Eye exam & treatment	70.33	62.59	-11	103.15	91.76	-11
92980		Insert intracoronary stent	847.93	587.08	-31	NA	NA	NA
93000		Electrocardiogram, complete	20.92	13.03	-38	20.92	13.03	-38
93010		Electrocardiogram report	9.02	6.80	-25	9.02	6.80	-25
93015		Cardiovascular stress test	100.27	61.74	-38	100.27	61.74	-38
93307	26	Tte w/o doppler, complete	49.77	35.97	-28	49.77	35.97	-28
93510	26	Left heart catheterization	248.86	169.36	-32	248.86	169.36	-32
98941	l	Chiropractic manipulation		24.36	-20	33.90	28.04	- 17

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT 1/				Facility			Non-facility	
HCPCS	MOD	Description	2009	2010²	Percent change	2009	2010²	Percent change
99203		Office/outpatient visit, new	68.17	60.04	- 12	91.97	81.00	- 12
99213		Office/outpatient visit, est	44.72	39.93	-11	61.31	54.09	- 12
99214		Office/outpatient visit, est	69.25	61.17	- 12	92.33	80.15	– 13
99222		Initial hospital care	122.63	106.77	- 13	NA	NA	NA
99223		Initial hospital care	180.33	156.05	- 13	NA	NA	NA
99231		Subsequent hospital care	37.15	30.87	-17	NA	NA	NA
99232		Subsequent hospital care	66.72	56.07	- 16	NA	NA	NA
99233		Subsequent hospital care	95.58	80.43	- 16	NA	NA	NA
99236		Observ/hosp same date	207.38	170.77	-18	NA	NA	NA
99239		Hospital discharge day	96.30	81.85	– 15	NA	NA	NA
99283		Emergency dept visit	61.31	49.84	- 19	NA	NA	NA
99284		Emergency dept visit	114.33	92.89	- 19	NA	NA	NA
99291		Critical care, first hour	212.07	173.89	-18	253.91	206.74	- 19
99292		Critical care, add Æl 30 min	106.04	86.94	-18	114.69	93.74	-18
99348		Home visit, est patient	NA	NA	NA	79.35	65.42	- 18
99350		Home visit, est patient	NA	NA	NA	160.86	137.92	-14
G0008		Admin influenza virus vac	NA	NA	NA	20.92	16.99	-19

¹ CPT codes and descriptions are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.C. of this proposed rule, the application of the 1.000 work GPCI floor, as extended by section 134(a) of the MIPPA, expires effective January 1, 2010. As a result, 54 (out of 89) PFS localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (-9.6 percent), followed by South Dakota (-5.8 percent), North Dakota (-5.3 percent), Rest of Missouri (-5.1 percent), and Montana (-5.0 percent).

C. Medicare Telehealth Services

In section II.D. of this proposed rule, we are proposing to add individual health behavior and assessment services (as described by HCPCS codes 96150 through 96152) to the list of telehealth services. We are also proposing to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately \$2 million. Previous additions to the list of telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that these proposals will provide more beneficiaries with access to these services, we do not anticipate that these proposed changes will have a significant

budgetary impact on the Medicare program.

D. MIPPA Provisions

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

This section of the MIPPA will have a positive impact on Medicare patients because coinsurance payment percentages for outpatient mental health services will be gradually reduced from January 1, 2010 through January 1, 2014. At the conclusion of this 5-year period, Medicare patients will pay the same coinsurance payment percentage for outpatient mental health services as they currently pay for other health services under the Medicare Part B program.

Since the inception of the Medicare Part B program, Medicare patients have been required to pay for a greater percentage of the cost of outpatient mental health treatment services than for other health services because of the Medicare payment limitation (the outpatient mental health treatment limitation). While a dollar cap that previously applied to mental health services was eliminated January 1, 1991, the statute maintained the 62½ percent limitation on the recognition of incurred expenses. This limitation of 621/2 percent reduces the program's payment for mental health services to 50 percent, leaving a Medicare patient responsible for paying the other half of these expenses through coinsurance. The 62½ percent limitation will remain in effect until December 31, 2009.

During the transition, the Medicare Part B program will incur increased expenditures as Medicare patients pay less out-of-pocket for outpatient mental health services until, in 2014, patients will pay only the deductible (if applicable) and 20 percent coinsurance. Section 102 of the MIPPA will shift cost-sharing for mental health services from Medicare patients to the program. This provision will result in a cost impact, to the Medicare program, of approximately \$100 million for CY 2010. As section 102 of the MIPPA is implemented, the impact of the changes to the coinsurance payment percentages (that is, recognized incurred expenses) for Medicare patients and the program is as shown in Table 41.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT PERCENTAGES UNDER SECTION 102 OF THE MIPPA

²Based upon projected –21.5 reduction in the conversion factor.

CY 2009 and prior calendar years—Medicare limitation, 62.50 percent of recognized incurred expenses.

Medicare Part B pays—50%.

Medicare Part B pays—50%.

CY 2010 and CY 2011—Medicare limitation, 68.75 percent of recognized incurred expenses.

Medicare Patient pays—45%.

Medicare Part B pays-55%.

CY 2012—Medicare limitation, 75 percent of recognized incurred expenses.

Medicare Patient pays—40%.

Medicare Part B pays-60%.

CY 2014—No limitation, 100.00 percent of recognized incurred expenses.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT Percentages Under Section 102 OF THE MIPPA—Continued

Medicare Patient pays-20%. Medicare Part B pays-80%.

2. Section 131 b: Physician Payment, Efficiency, and Quality Improvements— Physician Quality Reporting Initiative

As discussed in section II.G.2. of this proposed rule, the proposed 2010 PQRI measures satisfy the requirement of section 1848(k)(2)(D) of the Act that the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. As discussed in section II.G.2.d. of this proposed rule, we also propose to offer options in 2010 for reporting the proposed 2010 PQRI measures via submission of data to a clinical registry, options for reporting some of the proposed 2010 PQRI measures via submission of data extracted from an EHR, options for reporting on measures groups rather than individual measures, and options for group practices to be treated as satisfactorily submitting quality data under the PQRI.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the PQRI on providers.

With respect to satisfactory submission of data on quality measures by eligible professionals, one factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals

may employ different methods for incorporating the use of quality data codes into the office work flows. Therefore, we will continue to assign 3 hours as the amount of time needed for eligible professionals to review the PORI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of approximately \$50 per hour. To account for salary increases over time, we will use an average practice labor cost of \$55 per hour for our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we continue to estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows to be approximately \$165 per eligible professional (\$55 per hour × 3 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the Medicare Part B claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all the steps necessary to report 1 quality measure ranges from \$0.21 in labor time to about \$10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about \$0.90 in labor time per measure. Eligible professionals generally would be required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2010 PQRI will report an average of 3 measures each.

The cost of implementing claimsbased reporting of PQRI quality measures data also varies with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional

would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual cost per eligible professional associated with claims-based reporting to range from \$174.45 [(\$0.21 per measure $\times 3$ measures × 15 cases per measure) + \$165] to \$617.70 [(\$10.06 per measure × 3 measures × 15 cases per measure) +

For registry-based reporting, eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from a nominal charge for an eligible professional to use the registry to costing eligible professionals several thousand dollars. Thus, we conservatively estimate the cost incurred by an eligible professional to participate in PQRI via registry-based reporting to be approximately \$500 per eligible professional.

In addition, an eligible professional who chooses to submit PQRI quality measures results and numerator and denominator data on quality measures through a registry more than likely is already reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. Therefore, there should be little additional cost to the eligible professional associated with submitting

data to the registry.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf would need to complete a selfnomination process in order to be considered "qualified" to submit on behalf of eligible professionals. We estimate the registry self-nomination process to cost approximately \$500 per registry (\$50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of a \$50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from \$36 to \$84 per hour depending on experience, with an average rate of nearly \$50 per hour for a mid-level programmer.

The cost to the registry associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort

associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants.

For EHR-based reporting, an eligible professional generally would incur a cost associated with purchasing an EHR product. We estimate that it costs between \$1,500 to over \$5,000 to purchase an EHR product. Therefore, we conservatively estimate the average total cost to an eligible professional to be

approximately \$2,750.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered "qualified" for 2010. Therefore, one factor in the cost to EHR vendors is the cost associated with completing the selfnomination process in order for the vendor's EHR product(s) to be considered "qualified." Similar to the estimated cost to the registry associated with the registry self-nomination process, the estimated cost for an EHR vendor to complete the self-nomination process, including the vetting process with CMS officials, is conservatively estimated to be \$500 (\$50 per hour \times 10 hours per EHR vendor). Our estimate of a \$50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from \$36 to \$84 per hour depending on experience, with an average rate of nearly \$50 per hour for a mid-level programmer.

Another factor in the cost to EHR vendors is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The cost associated with the time and effort needed for an EHR vendor to review the quality measures and other

information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total cost to be approximately \$2,000 (\$50 per hour \times 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately \$10,000 per vendor (\$50 per hour \times 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. We estimate that the group practice staff involved in the group practice selfnomination process have an average labor cost of \$55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4

approximately \$220 (\$55 per hour \times 4

hours, we estimate the total cost to a

practice self-nomination process to be

group practice associated with the group

hours per group practice).

The cost associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on cost estimates for the Physician Group Practice (PGP) demonstration, which uses the same data submission methods as what we have proposed, we estimate the cost associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for

self-nomination + 79 hours for data submission). Based on an average labor cost of \$55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be \$4,565 (\$55 per hour × 83 hours per group practice).

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

As discussed in section II.G.3. of this proposed rule, section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the phased pilot physician feedback program to date.

4. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

Section II.G.5. of this proposed rule describes the proposed 2010 E-Prescribing Incentive Program. To be considered a successful e-prescriber in 2010, an eligible professional would need to meet the requirements proposed in section II.G.5.c. of this proposed rule.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and, potentially, EHR-based reporting for the electronic prescribing measure. We, however, do not anticipate a significant cost impact on the Medicare program since much of this infrastructure had already been established for the PQRI.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the E-

Prescribing Incentive Program on eligible professionals. Similar to claimsbased reporting for PQRI, one factor in the cost to eligible professionals, for those eligible professionals who choose to report the electronic prescribing measure through claims, is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately \$55 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately \$55 (\$55 per hour \times 1 hour).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all of the steps necessary to report 1 quality measure ranges from \$0.21 in labor time to about \$10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about \$0.90 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the electronic prescribing measure on a claim to be approximately \$0.90.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on our proposal to require an eligible professional to report the G8443 code for the electronic prescribing measure for at least 25 instances, we estimate the total annual estimated cost per eligible professional to report the electronic prescribing measure to be \$77.50 [(\$0.90 per measure × 1 measure × 25 cases per measure) + \$55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional cost for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program.

One potential cost to some eligible professionals associated with either claims-based reporting or registry-based reporting would be the cost of purchasing and using an e-prescribing system. There are currently many commercial packages available for eprescribing. One study indicated that a mid-range complete electronic medical record with electronic prescribing functionality costs \$2500 per license with an annual fee of \$90 per license for quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs \$1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). "Electronic

prescribing: a review of costs and

benefits." Topics in Health Information

Management 24(1): 29-38.). The cost to

an eligible professional of obtaining and

utilizing an e-prescribing system varies

package selected but also by the level at

employs information technology in his

or her practice and the level of training

not only by the commercial software

which the professional currently

needed.
Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the electronic prescribing measure for 2010.

The cost associated with the registrybased reporting requirements of this voluntary reporting initiative for the registry would be the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality

measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the cost associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting (if we finalize an EHR-based reporting mechanism for the E-Prescribing Incentive Program), the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The cost associated with an eligible professional reviewing the electronic prescribing measure and other information and determining whether the measure is applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, \$55 at a rate of \$55 per hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

With respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5.e. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claimsbased reporting of the electronic prescribing measure, we estimate the total annual estimated cost per group practice to be \$2,305 [(\$0.90 per measure \times 1 measure \times 2500 cases per measure) + \$55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to selfnominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would be no additional burden associated with the group practice selfnomination process for the E-Prescribing Incentive Program.

5. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services.

As discussed in section II.G.6. of this proposed rule, suppliers that provide the TC of advanced diagnostic imaging services will have to be accredited by an approved accreditation organization in order to receive Medicare reimbursement for advanced diagnostic imaging services described in section

1848(b)(4)(B) furnished to beneficiaries. This section of the rule will impact the suppliers that provide the TC of advanced diagnostic imaging services and the organizations that accredit suppliers of such services. Suppliers that provide the TC of advanced diagnostic imaging services will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers. To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of providers of care requiring accreditation.

Factors Affecting the Cost Impact

According to CMS' Services Tracking and Reporting System (STARS) database for 2008, there are a total of 1,137,278 physicians, IDTFs, hospitals and others billing Part B for the TC of advanced diagnostic imaging. This total includes both suppliers and providers that furnish items under Medicare Part B as suppliers.

Currently, there are suppliers accredited by one of three of the nationally recognized accreditation. We anticipate that the following accreditation organizations will seek approval from CMS to accredit suppliers that provide the TC of advanced diagnostic imaging services:

- American College of Radiology;
- Intersocietal Accreditation Commission: and
 - The Joint Commission.

Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all of the following items: Application fee, manuals, initial accreditation fee, onsite surveys or other auditing (generally once every 3 years), and travel, when necessary for survey personnel. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from the three accreditation organizations that currently accredit suppliers who provide the TC of advanced diagnostic imaging services. Based on all information we obtained, we estimate accreditation fees for each review cycle will be approximately \$5,000 for an advanced diagnostic imaging supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately \$1,666.

We recognize that becoming accredited may impose a burden on suppliers that provide the TC of advanced diagnostic imaging services, especially small suppliers. We have attempted to minimize that burden. We have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- Multiple accreditation organizations: We expect that more than one accrediting organization will apply to become and be designated as an advanced diagnostic imaging accrediting organization. We believe that selection of more than one accreditation organization will introduce competition resulting in reductions in accreditation costs.
- Required plan for small businesses: During the application process we will require accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty suppliers. This will need to include that the accreditation organization's fees are based on the size of the organization.
- Reasonable quality standards: The quality standards that will be used to evaluate the services rendered for each imaging modality are industry standards. Many suppliers that provide the TC of advanced diagnostic imaging services already comply with the standards and have incorporated these practices into their daily operations. We have been told that that those suppliers with private insurance contracts must be accredited, thus our requirements would not be duplicative. It is our belief and has been stated by those suppliers already accredited that compliance with the quality standards will result in more efficient and effective business practices and will assist suppliers in reducing overall costs.

Other Accreditation Costs

It is difficult to precisely estimate the costs of preparing for accreditation. We do recognize there is cost to the supplier in order to come into compliance initially and thus prepare for the accreditation survey. This should result in minimal preparation and cost.

Additional Considerations

There are at least two important sources of uncertainty in estimating the impact of accreditation on suppliers that provide the TC of advanced diagnostic imaging services. First, our estimates assume that all current suppliers with positive Medicare payments will seek accreditation. We assume that suppliers who currently receive no Medicare allowed charges will choose not to seek

accreditation. It is also possible that many of the suppliers with allowed charges between \$1 and \$10,000 may decide not to incur the costs of accreditation.

Second, it is unclear what accreditation fees will be in the future. However, we are requiring the accreditation organization to submit their fees that are based on the size of the supplier, or on the amount billed. Our experience with another accreditation program has lead us to believe that the accreditation rates will go up, although minimally, if travel costs continue to rise.

In summary, suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012. In the options we have proposed we have attempted to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that consider the small suppliers. Also, the fact that the surveys will be either performed as a desk review or unannounced deletes the time and cost for the accreditation organization in travel, if required.

6. Section 139: Improvements for Medicare Anesthesia Teaching Programs

As discussed in section II.G.7., this proposed rule would provide for increased payments under the Medicare PFS for certain cases involving teaching anesthesiologists with anesthesia residents or for teaching CRNAs with student nurse anesthetists. This provision of the MIPPA is anticipated to have a minimal budgetary impact.

7. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Cardiac Rehabilitation Services

Current levels of coverage for CR programs will continue under this rule, and new ICR programs will likely develop and request designation by CMS to receive Medicare payments. Because section 144(a) of the MIPPA requires higher payments for ICR programs than for CR programs, this expansion of coverage will result in greater costs to the Medicare program. The requirements for ICR programs, also required in section 144(a) of the MIPPA, are extensive and will likely limit the number of programs that request designation as ICR programs by CMS. As a result, significantly fewer ICR

programs than CR programs will function throughout the country; however, we currently do not know how many ICR programs may request designation.

We believe that the proposed expansion of coverage for ICR programs will enable beneficiaries to take advantage of more focused and rigorous programs that will more quickly lead to improved cardiovascular health. Having the choice of CR and ICR programs, beneficiaries eligible for coverage will be able to determine the best manner in which to achieve improved cardiovascular health, through traditional CR or more rigorous ICR programs. We also expect this proposed expansion of coverage to bring more attention to the importance of cardiac rehabilitation and the extensive benefits these programs provide to beneficiaries. As a result, the number of beneficiaries participating in CR programs may increase. We estimate that the proposed provisions for establishing coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs, as discussed in section II.G.8. of this proposed rule, will have a minimal budgetary impact on the Medicare program.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Pulmonary Rehabilitation Services

As discussed in section II.G.9. of this proposed rule, the implementation of the Medicare pulmonary rehabilitation program will allow Medicare, for the first time, to provide for payment for exercise and other services as part of a comprehensive treatment plan for beneficiaries with moderate to severe COPD. We believe this program has the potential of not only improving the quality of life for beneficiaries who engage in it, but also reducing Medicare costs in the long range by decreasing the chances of exacerbations and further rehabilitation related to their chronic respiratory disease. We estimate this provision will have a minimal budgetary impact on the Medicare program.

9. Section 152(b): Coverage of Kidney Disease Patient Education Services

The implementation of Medicare coverage of kidney disease patient education services as discussed in section II.G.10. of this proposed rule will allow Medicare to provide for payment for kidney disease education services for beneficiaries with Stage IV chronic kidney disease. We believe this program can help patients achieve better

understanding of their illness, dialysis modality options, and may help delay the need for dialysis. We believe this program has the potential of improving the quality of life for beneficiaries since they will be better equipped to make informed decisions. We estimate a cost to the Medicare program of approximately \$10 million for CY 2010, because the statute limits the number of kidney disease education sessions to 6, as a lifetime maximum.

10. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in section V.F. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

11. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemother

We anticipate that the proposals related to the compendia discussed in section II.G.12. of this proposed rule will have a negligible cost to the Medicare program and to the public. The information that is required to be collected and published on the compendia Web sites is information that is already collected in the normal course of business by the compendia publishers, which all have Web sites. The proposed changes will enable CMS to efficiently implement the provisions of section 182(b) of the MIPPA that require transparent evaluative and conflict of interest policies and practices for current and future listed compendia on and after January 1, 2010.

E. Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Issues

The proposed changes discussed in section II.F.1. of this proposed rule with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures as we are not proposing any change to the AMP/WAMP threshold and the proposed change concerning the immunosuppressive drug period of eligibility is a comforming change to reflect the statute.

2. Competitive Acquisition Program (CAP) Issues

As discussed in section II.F.2., this proposed rule contains proposals and seeks comment on certain aspects of the CAP, specifically the frequency of drug

payment amount updates, changes to the CAP drug list, the geographic area served by the CAP, CAP drug stock at the physician's office, exclusion of CAP sales from ASP calculations, the annual CAP payment amount update mechanism, and updates to proposals made in the 2009 PFS rule. Our changes and refinements may improve compliance, promote program flexibility, improve the quality, and maintain the availability of services for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system for two reasons. First, in 2006 through 2008, the dollar volume of claims paid under the CAP was small compared to the volume of claims paid under section 1847A of the Act, and although we anticipate that the CAP will continue to grow, we do not anticipate a significant change in the proportion of claims paid under these payment systems. Second, because CAP payment amounts are limited to prices calculated under section 1847A of the Act, we expect payment rates for the two programs to remain very similar.

F. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in sections II.G.11. and II.I. of this proposed rule. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2009 payments) to estimated payments under the revisions to the composite rate payment system (CY 2010 payments) as discussed in section II.I. of this proposed rule. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2009 payments and proposed 2010 payments.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the December 2008 update of CY 2008 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2008

update of the CY 2008 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section II.I. of this proposed rule. To update the treatment counts we used the ratio of the June 2008 to the December 2007 updates of the CY 2007 National Claims History File figure for treatments. This was an increase of 11.3 percent. Due to data limitations, we are unable to estimate current and proposed payments for 57 of the 5048 ESRD facilities that bill for ESRD dialysis treatments.

Table 42 shows the impact of this year's proposed changes to CY 2010 payments to hospital-based and independent ESRD facilities. The first column of Table 42 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of all proposed changes to the ESRD wage index for CY 2010 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in CY 2010 to aggregate ESRD wage adjusted composite rate payments in CY 2009. In CY 2009, ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate, ending a 4-year transition period in which they had received an increasing percent of payments based on the CBSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2010 ESRD wage index has been multiplied by a Budget Neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index.

The fifth column shows the effect of proposed changes to the ESRD wage index in CY 2010 and the effect of the MIPPA provisions on ESRD facilities. Section 153(a) of the MIPPA amended section 1881(b)(12)(G) of the Act to revise payments to ESRD facilities. Effective January 1, 2010, there is an update of 1 percent to the composite rate component of the payment system.

The sixth column shows the overall effect of the proposed changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the difference between the proposed CY 2010 payment with all changes as

proposed in this rule and current CY 2009 payment. This payment amount is computed by multiplying the wage adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2008 claims. The CY 2010 proposed payment is the composite rate for each provider (with the proposed 15.0 percent drug add-on) times dialysis treatments from CY 2008 claims. The

CY 2009 current payment is the composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2008 claims.

The overall impact to ESRD providers in aggregate is 0.8 percent as shown in Table 42. Most ESRD facilities will see an increase in payments as a result of the MIPPA provision. While the MIPPA provision includes a 1 percent increase

to the ESRD composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this proposed rule is a 0.8 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.8 percent and payments to hospital-based ESRD facilities will increase by 1.0 percent.

TABLE 42—IMPACT OF CY 2010 CHANGES IN PAYMENTS TO HOSPITAL BASED AND INDEPENDENT ESRD FACILITIES [Percent change in composite rate payments to ESRD facilities]

		ı			
	Number of facilities	Number of dialysis treat- ments (in millions)	Effect of changes in wage index ¹ (percent)	Effect of changes in wage index and of MIPPA provision ² (percent)	Overall effect of wage index MIPPA & drug add-on ³ (percent)
1	2	3	4	5	6
All Providers	4,991	37.1	0.0	1.0	0.8
Independent	4,432	33.5	0.0	1.0	0.8
Hospital Based	559	3.6	0.2	1.2	1.0
By Facility Size:					
Less than 5,000 treatments	1,807	5.3	0.1	1.1	0.9
5,000 to 9,999 treatments	1,998	14.6	0.0	1.0	0.9
Greater than 9,999 treatments	1,186	17.2	-0.1	0.9	0.8
Type of Ownership:					
Profit	4,062	30.5	0.0	1.0	0.8
Nonprofit	929	6.5	0.1	1.1	0.9
By Geographic Location:					
Rural	1,093	6.0	0.2	1.2	1.0
Urban	3,898	31.0	0.0	1.0	0.8
By Region:					
New England	156	1.3	0.3	1.3	1.1
Middle Atlantic	571	4.6	-0.2	0.8	0.6
East North Central	808	5.8	-0.1	0.9	0.7
West North Central	382	2.0	0.3	1.3	1.1
South Atlantic	1,129	8.5	0.1	1.1	0.9
East South Central	388	2.8	0.2	1.2	1.0
West South Central	679	5.3	0.0	1.0	0.8
Mountain	279	1.6	0.9	1.9	1.7
Pacific	562	4.8	-0.1	0.9	0.7
Puerto Rico & Virgin Islands	37	0.4	-2.4	-1.4	-1.6

¹This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the proposed CY 2010 wage indexes which are compared to composite rate payments using the current CY 2009 wage indexes.

²This column shows the effect of the changes in the Wage Indexes and the MIPPA provision which includes a 1 percent increase to the com-

posite rate. This provision is effective January 1, 2010.

G. Chiropractic Demonstration— Application of Budget Neutrality

As discussed in section II.J. of this proposed rule, we are proposing to recoup the \$50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. We would recoup \$10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014.

To implement this required BN adjustment, we would reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT

codes 98940, 98941, and 98942) by 2

H. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

The revisions to the conditions of participation (CoP) discussed in section II.K. of this proposed rule make technical corrections and update the regulations to reflect current industry standards for respiratory therapists. The revisions to the regulations will clarify the qualifications necessary for respiratory therapists' to continue to

qualify to furnish respiratory therapy services to CORF patients. These changes are similar to prior rules and will have no impact on CORFs cost.

I. Physician Self-Referral Provisions

As discussed in section II.N. of this proposed rule, we expect that our proposed clarification of the physician stand in the shoes provisions will assist designated health services entities in structuring legitimate compensation arrangements. Furthermore, like other physician self-referral policies, we anticipate that this clarification will

³This column shows the percent change between CY 2010 and CY 2009 composite rate payments to ESRD facilities. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase due to MIPPA effective January 1, 2010 and the drug add-on of 15.0 percent. The CY 2009 payments include the CY 2009 wage adjusted composite rate, a 1 percent increase and site neutral rates effective January 1. ary 1, 2009 and the drug add-on of 15.2 percent. This column shows the effect of wage index, MIPPA, and drug add-on changes.

result in savings to the Medicare program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any certainty the extent of these savings to the program.

K. Durable Medical Equipment Related Issues

1. Damages Process

In section II.O.1. of this proposed rule, we propose to establish a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their supplier contracts by MIPPA. The DMEPOS Competitive Bidding Program that was implemented on July 1st, 2008, awarded contracts to 329 suppliers. The following factors may be considered by a contract supplier before deciding to submit a claim:

- The contract itself stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program;
- The contract does not guarantee any amount of business or profits, therefore, an efficient business would not be expected to incur large expenses without any guaranteed increase in business and profits;
- The contract stipulates that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized pursuant to the contract;
- Upon termination of the contracts by MIPPA, payments reverted back to the fee schedule amount, which was on average 26 percent higher than under the DMEPOS Competitive Bidding Program.
- There is a required responsibility under contract law for a company to take action to mitigate expenses to any stop work order.
- CMS listed the winning suppliers on the Medicare Web site at http://www.Medicare.gov in the supplier locator tool, a supplier is allowed to keep any new customers they may have obtained as a result of being listed on the supplier locator tool.

By mentioning the list above, we are not suggesting that there would not be legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

Based on these reasons and because there have been so few inquiries or responses to the reference in the MIPPA to damages (fewer than 7 suppliers), we believe that as few as 1 percent of the 329 winning suppliers may make a claim for damages. However, as a high

estimate, we would estimate that approximately 76 percent of the suppliers (250) may submit a claim. We anticipate that it will take approximately 3 hours at \$34/hour (3 × \$34 = \$102) for an accountant and a company official to review and gather the necessary documents to file a claim for a total of \$25,500 (250 \times \$102). The hourly accountant rate was based on the Bureau of Labor Statistics data collected for June 2006 which was then adjusted to account for inflation. We estimate that this regulation will not have a large budgetary impact. The total cost range of \$408 to \$25,500 for potential claims from contract suppliers will not result in expenditures of \$133 million or more annually. An analysis of the damage payments that may result would be dependent upon an evaluation of the actual claims once they are received.

2. Grandfathering Process

In section II.O.2. of this proposed rule, we are proposing to revise the definition of a grandfathered item to refer to all rented items within a competitively bid product category that the supplier currently rents. The proposed definition of a grandfathered item would avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code.

We also believe the revision of this definition would have a negligible impact on suppliers as product categories consist of related items routinely provided by suppliers. We are only requiring a supplier to provide those rented items within a product category that the supplier was currently furnishing at the start of the competitive bidding program.

While difficult to estimate, we believe that based on 2008 data, there were approximately 1,850 suppliers in the 9 CBAs, for which we will be doing the Round 1 rebid that rented competitively bid items, on average at different points in time during 2008. Therefore, we are using this number to indicate how many suppliers would be renting a DME

competitively bid item at the start of the competitive bid program. We believe some suppliers may decide not to bid because of the cost of bidding and accreditation requirements while other suppliers may not qualify for a contract. Since not all suppliers will be awarded contracts and some may not choose to submit a bid, we estimate that in the worst case scenario there will be 1,450 suppliers that will not be awarded contracts, would be renting DME competitive bid items at the time the program is implemented.

Based on our experience from the competitive bidding demonstrations, of the 1,450 suppliers who are not awarded a contract, we expect 90 percent or 1,305 of these noncontract suppliers will offer to be grandfathered suppliers $(0.90 \times 1,450 = 1,305)$ and 10 percent or 145 $(0.10 \times 1,450 = 145)$ of the suppliers will choose not to grandfather. We believe most suppliers will not want to pick up their items before the end of the full rental period.

Based on 2008 data, we estimate that there will be 96,000 beneficiaries who reside in a CBA and are renting competitively bid items from suppliers at the start of the round 1 rebid. Based on the 2007 round 1 of the competitive bidding program, we estimate that there would be 74,880 ($96,000 \times 0.78 = 74,880$) beneficiaries who would be renting items from a noncontract supplier.

Notification Requirement for Suppliers That Choose to Grandfather

a. Notification to CMS

For those suppliers that choose to grandfather (1,305), we estimate that it would take the supplier on average 2 hours to develop the 30-day notification that it is required to send to CMS. We estimate that the cost to the supplier to develop the 30-day notification to CMS would be \$89.60 for skilled administrative staff (2 hours \times \$44.80 per hour). The \$44.80 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate that the cost to the supplier to send the notification to CMS would be \$5.51 for clerical staff (0.25 hour to send the notification \times \$22.02 per hour = \$5.51). The \$22.02 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate the cost of supplies necessary to send the notification would be \$2.00. The total cost for sending the notification would be \$7.51 which includes the cost of clerical staff (\$5.51) and supplies (\$2.00). The individual costs for all suppliers to notify CMS would be

\$97.11 (\$89.60 for development of the letter + \$7.51 for preparing and sending each notification = \$97.11). The overall cost for suppliers to notify CMS would be approximately \$126,728.55 (\$97.11 per supplier \times 1,305 suppliers = \$126,728.55).

b. Notification to the Beneficiary

We estimate based on 2008 data, we expect that there will be 74,880 beneficiaries who would have been renting competitive bid items from a noncontract supplier at the start of the round 1 rebid of the CBP. Of the 74,880, we believe that approximately 100 percent of these beneficiaries will accept the offer to continue to rent competitively bid items from the noncontract supplier that offers to be a grandfathered supplier. We believe that the beneficiaries will choose to continue to rent from a grandfathered supplier if given the choice because it would be more convenient, assure continuity of care, and eliminate the need to have equipment taken from their home.

Based upon the number of suppliers and beneficiaries, we estimate that there would be an average of 52 beneficiaries per supplier that was not awarded a contract (74,880 beneficiaries/1,450 suppliers = 52). Therefore, we estimate that each noncontract supplier that chooses to grandfather would send the 30-day notification on average to 52 beneficiaries.

We expect that the cost of developing the 30-day notification to a beneficiary would be equivalent to the cost of developing the 30-day notification to CMS (\$89.60 per notification). We also expect the cost of sending the 30-day notification per beneficiary to be equivalent to sending the 30-day notification to CMS (\$7.51 per notification). The total costs for the 30day notification to beneficiaries for suppliers that choose the grandfathering option would be \$89.60 for development of the letter, and \$7.51 for preparing and sending each notification. To calculate the total cost we multiplied $$7.51 \times 52$ beneficiaries and added the development cost for the letter of \$89.60 for a total of \$480.12 per supplier. The overall cost for these suppliers to provide the 30-day notification to their beneficiaries would be approximately \$626,556.60 (\$480.12 per supplier \times 1,305 suppliers = \$626,556.60).

Notification Requirement for Suppliers That Choose Not to Grandfather

a. 30-Day Notification to the Beneficiary

We expect that suppliers who choose not to grandfather will incur costs equivalent to the cost of developing and sending the 30-day notification to a beneficiary by those suppliers that choose to grandfather. The overall cost for all suppliers who choose not to grandfather to provide the 30-day notification to the beneficiary is approximately \$69,617.40 (\$480.12 total cost per supplier \times 145 nongrandfathered suppliers = \$69,617.40). The estimate of 145 suppliers not choosing to be grandfathered suppliers represents 10 percent of the total number of noncontract suppliers.

While the cost for the 30-day notification to beneficiaries will be exactly the same for all suppliers, those who choose not to become a grandfathered supplier will also incur the cost of the 10-day and 2-day notification.

b. 10-Day and 2-Day Notification

For the 10-day notification to a beneficiary, we estimate the supplier would make at least 1 phone call that would take an average of 15 minutes to discuss that the beneficiary must switch to a contract supplier, the schedule for picking up the current equipment by the noncontract supplier, and the delivery of new equipment by the contract supplier. For the 2-day notification to the beneficiary, we estimate that the supplier would make at least 1 phone call that would take an average of 15 minutes to ensure that all of the arrangements are finalized and to answer any last minute questions. We anticipate that clerical staff would perform both of these tasks.

The estimated cost of the 10-day notification totals \$5.51 (.25 of an hour ×\$22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = \$5.51). The estimated cost of the 2-day notification totals \$5.51 (.25 of an hour \times \$22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = \$5.51). Therefore, the 10-day and 2-day notifications for each supplier would cost approximately \$11.02. The total cost for each supplier would be approximately \$573.04 (\$11.02 × 52 beneficiaries = \$573.04). The overall impact for all suppliers to make the 10day and 2-day notifications would be approximately \$83,090.80 (145 suppliers × \$573.04 per supplier = \$83,090.80).

We anticipate that this proposed process will not place a greater burden on the overall small supplier community. This process is only going to affect those small suppliers that were renting items when the competitive bidding program begins and who did not win a contract. The burden on these suppliers would generally be less

because small suppliers will have fewer beneficiaries to furnish notifications to.

As an alternative, we considered relying on suppliers to develop their own schedule for informing beneficiaries regarding grandfathering. This alternative would have left the beneficiaries vulnerable to having equipment removed from the home before new equipment was delivered. The process proposed in this regulation ensures the beneficiaries can make an informed decision about the transition policy that works best for them. The alternative we selected ensures the beneficiaries will have continued access to medically necessary items and be properly informed about the steps they must take so that their services will not be interrupted.

U. Alternatives Considered

This proposed rule contains a range of policies, including some provisions related to specific MIPPA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered.

V. Impact on Beneficiaries

There are a number of changes in this proposed rule that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the coding provisions related to the IPPE and consultation services, the changes with respect to telehealth services, the kidney disease patient education, pulmonary rehabilitation and intensive cardiac rehabilitation proposals will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Additionally, the proposed grandfathering process for DME suppliers will help ensure that beneficiaries are contacted and informed about this process and the choices they have concerning whether or not to use a grandfathered supplier. Moreover, the notice will help to ensure that beneficiaries do not have necessary DME equipment taken from them unexpectedly by a noncontact supplier.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular

provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2010, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be \$399. In addition, the portion of the 2010 standard monthly Part B premium attributable to PFS services is estimated to be \$25.00.

To illustrate this point, as shown in Table 39, the 2009 national payment

amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is \$91.97 which means that in 2009 a beneficiary is responsible for 20 percent of this amount, or \$18.39. Based on this rule, the 2010 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 39, is \$81.00 which means that, in 2010, the beneficiary coinsurance for this service would be \$16.20.

Policies discussed in this rule, such as the coding changes with respect to the RVUs for IPPE and the changes to consultation services, would similarly impact beneficiaries' coinsurance. W. Accounting Statement

As required by OMB Circular A–4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 43, we have prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. This estimate includes the incurred benefit impact associated with the estimated CY 2010 PFS update based on the 2009 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

Table 43—Accounting Statement: Classification of Estimated Expenditures CY 2010

Category	Transfers
Annualized Monetized TransfersFrom Whom To Whom?	Estimated decrease in expenditures (from CY 2009 to CY 2010) of \$13.3 Billion. Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
Annualized Monetized Transfers	Estimated increase in expenditures of \$110 Million for MIPPA Provisions (sections 102 and 152(b)).
From Whom To Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

2. Section 410.30 is amended by revising paragraph (b) to read as follows:

§ 410.30 Prescription drugs used in immunosuppressive therapy.

* * * * *

(b) Eligibility. For drugs furnished on or after December 21, 2000, coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who received an organ or tissue transplant for which Medicare payment is made, provided the individual is eligible to receive Medicare Part B benefits.

3. Section 410.47 is added to read as follows:

§ 410.47 Pulmonary rehabilitation program: Conditions for coverage.

(a) Definitions.

Individualized treatment plan means a written plan established, reviewed, and signed by a physician every 30 days, that describes all of the following:

(i) The individual's diagnosis.

- (ii) The type, amount, frequency, and duration of the items and services under the plan.
- (iii) The goals set for the individual under the plan.

Outcomes assessment means a written evaluation of the patient's progress as it relates to the individual's rehabilitation which includes the following:

(i) Beginning and end evaluations, based on patient-centered outcomes, which are conducted by the physician at the start and end of the program.

(ii) Objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance and self-reported measures of shortness of breath and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

Psychosocial assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

Pulmonary rehabilitation means a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(b) Beneficiaries who may be covered.
(1) Medicare covers pulmonary rehabilitation for beneficiaries with moderate to severe COPD (defined as

GOLD classification II and III), when referred by the physician treating the

chronic respiratory disease.

(2) Additional medical indications for coverage for pulmonary rehabilitation program services may be established through a national coverage determination (NCD).

(c) Components. Pulmonary rehabilitation includes all of the

following components:

(1) Physician-prescribed exercise. This physical activity includes techniques such as exercise conditioning, breathing retraining, step and strengthening exercises. Some aerobic exercise must be included in each pulmonary rehabilitation session.

(2) Education or training. (i) Education or training closely and clearly related to the individual's care and treatment which is tailored to the

individual's needs.

(ii) Education includes information on respiratory problem management and, if appropriate, brief smoking cessation

counseling.

- (iii) Any education or training prescribed must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations and improved quality of life.
- (3) Psychosocial assessment. The psychosocial assessment must meet the criteria as defined in paragraph (a) of this section and includes:
- (i) An assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment.

(ii) A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(4) Outcomes assessment. The outcomes assessment must meet the criteria as defined in paragraph (a) of this section.

(5) *Individualized treatment plan.* The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

(d) Settings. (1) Medicare Part B pays for a pulmonary rehabilitation in the

following settings:

(i) Physician's offices.

(ii) Hospital outpatient settings.

- (2) All settings must have the following available for immediate use and accessible at all times:
- (i) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.
- (ii) A physician must be immediately available and accessible for medical

- consultations and emergencies at all times when services are being provided under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27(f) of this subpart.
- (e) Physician standards. Medicare Part B pays for pulmonary rehabilitation services provided by a physician only if the physician meets all of the following requirements:
- (1) Has expertise in the management of individuals with respiratory pathophysiology.
- (2) Is licensed to practice in the State in which the pulmonary rehabilitation program is offered.
- (3) Is responsible and accountable for the pulmonary rehabilitation program.
- (4) Is involved substantially in consultation with staff in directing the progress of the individual in the program.
- (f) Limitations on coverage: Sessions. Medicare Part B pays for services provided in connection with a pulmonary rehabilitation exercise program for up to 36 sessions, no more than one session per day.
- (g) Effective date. Coverage for pulmonary rehabilitation program services is effective January 1, 2010.
- 4. Section 410.48 is added to read as follows:

§ 410.48 Kidney disease education services.

(a) Definitions.

Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease.

Physician means a physician as defined in section 1861(r)(1) of the Act.

- Qualified person means either of the following healthcare entities that meets the qualifications and requirements specified in this section to provide kidney disease patient education services—
- (i) One of the following healthcare professionals who furnishes services for which payment may be made under the physician fee schedule:
- (A) Physician (as defined in section 1861(r)(1) of the Act).
- (B) Physician assistant (as defined in section 1861(aa)(5) of the Act and § 410.74 of this subpart).
- (C) Nurse practitioner (as defined in section 1861(aa)(5) of the Act and § 410.75 of this subpart).

- (D) Clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and § 410.76 of this subpart),
- (ii)(A) Hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that is located in a rural area as defined in § 412.64(b)(ii)(C); or
- (B) A hospital or critical access hospital that is treated as being rural under § 412.103 of this chapter.

Renal dialysis facility means a unit which is approved to furnish dialysis service(s) directly to end-stage renal disease (ESRD) patients, as defined in § 405.2102 of this chapter.

Stage IV chronic kidney disease means kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m², using the Modification of Diet in Renal Disease (MDRD) Study formula.

- (b) Covered beneficiaries. Medicare Part B covers outpatient kidney disease patient education services if the beneficiary meets all of the conditions and requirements of this subpart, including all of the following:
- (1) Is diagnosed with Stage IV chronic kidney disease.
- (2) Obtains a referral from the physician (as defined in section 1861(r)(1) of the Act) managing the beneficiary's kidney condition.
- (c) Qualified person. (1) Medicare Part B covers outpatient kidney disease patient education services provided by a qualified person as defined in paragraph (a) of this section and must be able to properly receive Medicare payment under part 424 of this chapter.

(2) A qualified person does not include either of the following:

- (i) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice if kidney disease patient education services are provided outside of a rural area as defined in § 412.64(b)(ii)(C) of this chapter unless the services are furnished in a hospital or critical access hospital that is treated as being in a rural area under § 412.103 of this chapter.
- (ii) A renal dialysis facility, as defined in § 405.2102 of this chapter.
- (d) Standards for content of kidney disease patient education services. The content of the kidney disease patient education services includes the following:
- (1) The management of comorbidities including for the purpose of delaying the need for dialysis which includes, but not limited to, the following topics:

- (i) Prevention and treatment of cardiovascular disease.
- (ii) Prevention and treatment of diabetes.
- (iii) Hypertension management.
- (iv) Anemia management.
- (v) Bone disease and disorders of calcium and phosphorus metabolism management.
- (vi) Symptomatic neuropathy management.
- (vii) Impairments in functioning and well-being.
- (2) The prevention of uremic complications which includes, but not limited to, the following topics:
- (i) Information on how the kidneys work and what happens when the kidneys fail.
- (ii) Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival.
 - (iii) Diet and fluid restrictions.
- (iv) Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug.
- (3) Therapeutic options, treatment modalities and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney:
- (i) Hemodialysis, both at home and infacility.
- (ii) Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility.
 - (iii) All vascular access options.
 - (iv) Transplantation.
- (4) Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved which includes, but not limited to, the following topics:
 - (i) Physical symptoms.
 - (ii) Impact on family and social life.
 - (iii) Exercise.
 - (iv) The right to refuse treatment.
 - (v) Impact on work and finances.
 - (vi) The meaning of test results.
 - (vii) Psychological impact.
- (5) Qualified persons must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment.
- (i) The outcomes assessments serve to assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to chronic kidney disease.

- (ii) The outcomes assessments serve to assess the program's effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.
- (iii) The assessment must be administered to the beneficiary during a kidney disease education session.
- (iv) The outcomes assessments must be made available to CMS upon request.
- (e) Limitations for coverage of kidney disease education services. (1) Medicare Part B makes payment for up to 6 sessions of kidney disease patient education services.
- (2) A session is 60 minutes long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries.
- (f) Effective date. Medicare Part B covers kidney disease patient education services for dates of service on or after January 1, 2010.
- 5. Section 410.49 is added to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

(a) Definitions.

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following:

- (i) A description of the individual's diagnosis.
- $(i\bar{i})$ The type, amount, frequency, and duration of the items and services furnished under the plan.
- (iii) The goals set for the individual under the plan.

Intensive cardiac rehabilitation (ICR) means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements described in paragraph (c) of this section.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

(i) Minimally, assessments from the commencement and conclusion of cardiac rehabilitation and intensive cardiac rehabilitation, based on patientcentered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program.

(ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Physician-prescribed exercise means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(b) General rule. (1) Covered beneficiary rehabilitation services. Medicare part B covers cardiac rehabilitation and intensive cardiac rehabilitation programs, as defined in this section, for beneficiaries who have experienced one or more of the following:

(i) An acute myocardial infarction

within the preceding 12 months.

(ii) A coronary artery bypass surgery.

- (iii) Current stable angina pectoris.(iv) Heart valve repair or replacement.
- (v) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
 - (vi) A heart or heart-lung transplant.
- (vii) For cardiac rehabilitation only, other conditions as specified through a national coverage determination.
- (2) Components of a cardiac rehabilitation program. Cardiac rehabilitation programs must include all of the following:
- (i) Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.
- (ii) Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.
 - (iii) Psychosocial assessment.
 - (iv) Outcomes assessment.
- (v) An individualized treatment plan detailing how components are utilized for each patient.
- (3) *Settings*. (i) Medicare Part B pays for cardiac rehabilitation and intensive cardiac rehabilitation in one of the following settings:
 - (A) A physician's office.
 - (B) A hospital outpatient setting.
- (ii) All settings must have a physician, as defined in this section, immediately available and accessible for medical

consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27 of this subpart.

- (c) Standards for an intensive cardiac rehabilitation program. (1) To be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the following for its patients:
- (i) Positively affected the progression of coronary heart disease.
- (ii) Reduces the need for coronary bypass surgery.
- (iii) Reduces the need for

percutaneous coronary interventions.

- (iv) A statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:
 - (A) Low density lipoprotein.
 - (B) Triglycerides.
 - (C) Body mass index.
 - (D) Systolic blood pressure.
 - (E) Diastolic blood pressure.
- (F) The need for cholesterol, blood pressure, and diabetes medications.
- (2) A list of designated intensive cardiac rehabilitation programs will be posted to the CMS Web site and listed in the **Federal Register**.
- (3) To ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation, sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site.
- (i) Sites will be notified of continued compliance via a re-evaluation date posted to the CMS Web site.
- (ii) Sites that are no longer designated as approved intensive cardiac rehabilitation programs, due to poor outcomes data resulting in noncompliance, will be notified in writing and removed from the CMS Web site.
- (d) Standards for physicians responsible for cardiac rehabilitation programs. A physician who serves as the program Medical Director responsible for general or intensive cardiac rehabilitation programs, and

who, in consultation with staff, is involved in directing the progress of individuals in the program must possess all of the following:

(1) Expertise in the management of individuals with cardiac

pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

- rehabilitation program is offered.
 (e) Standards for supervisingphysicians. Physicians acting as the supervising-physician must possess all of the following:
- (1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

- (f) Limitations for coverage of cardiac rehabilitation programs. (1) General cardiac rehabilitation. The number of general cardiac rehabilitation program sessions are limited to a minimum of 2 1-hour sessions per week and a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 18 weeks. Medicare contractors have discretion to expand these limitations to not exceed 72 sessions for 36 weeks.
- (2) Intensive cardiac rehabilitation: Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.
- 6. Section 410.78 is amended by— A. Revising the introductory text of paragraph (b).
 - B. Revising paragraph (e). The revisions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) General rule. Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs, and individual health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

(e) *Limitations*. (1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a

telecommunications system, but may not seek payment for medical evaluation and management services.

(2) The physician visits required under § 483.40(c) of this title may not be furnished as telehealth services.

* * * * *

Subpart I—Payment of SMI Benefits

7. Section 410.155 is amended by—A. Revising paragraphs (a), (b)(2)(i), (b)(2)(ii), (b)(2)(iv), (b)(2)(v), and (c).

B. Adding paragraph (b)(3).

The revisions and addition read as follows:

§ 410.155 Outpatient mental health treatment limitation.

- (a) Limitation. For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160, respectively, is as follows:
- (1) For expenses incurred in years before 2010, $62\frac{1}{2}$ percent.
- (2) For expenses incurred in 2010 and 2011, 683/4 percent.
- (3) For expenses incurred in 2012, 75 percent.
- (4) For expenses incurred in 2013, 81½ percent.
- (5) For expenses incurred in CY 2014 and subsequent years, 100 percent.
 - (b) * *
- (2) Services not subject to the limitation. Services not subject to the limitation include the following:
- (i) Services furnished to a hospital inpatient.
- (ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders billed under HCPCS code M0064 (or its successor).
 - (iii) * * *
- (iv) Diagnostic services, such as diagnostic psychological and neuropsychological testing, that are performed to establish a diagnosis.
- (v) Medical management services billed under CPT code 90862 (or its successor), as opposed to psychotherapy, when furnished to a patient diagnosed with Alzheimer's disease or a related disorder.
- (3) Payment amounts. The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses (%)	Patient pays (%)	Medicare pays (%)
CY 2009 and prior calendar years CYs 2010 and 2011 CY 2012 CY 2013 CY 2014	62.50	50	50
	68.75	45	55
	75.00	40	60
	81.25	35	65
	100.00	20	80

(c) General formula. A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved: and.

- (3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.
- (4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

8. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

9. Section 411.354 is amended by revising paragraph (c)(3)(i) to read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

(c) * * * * * *

(3)(i) For purposes of paragraphs (c)(1)(ii) and (c)(2)(iv), a physician who "stands in the shoes" of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated

"between the parties" are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

PART 414—PAYMENT FO

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

10. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart A—General Provisions

§ 414.1 [Amended]

11. Amend § 414.1 by adding "1834(e)—Implementation of accreditation standards for suppliers furnishing the technical component of advanced imaging services" in numerical order.

Subpart B—Physicians and Other Practitioners

12. Section 414.46 is amended by revising paragraphs (d)(2) and (e) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * * * (d) * * *

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident. For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical

direction payment rules as specified in paragraph (e) of this section.

* * * * *

(e) Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases. For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. The single anesthesia resident case is the only case or concurrent to one other anesthesia case that is being medically directed by the physician.

13. Section 414.61 is added to read as follows:

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

- (a) Basis for payment. Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:
- (1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.
- (2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

- (b) Level of payment. The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in 414.46(c) of this subpart.
- 14. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy. and individual health and behavior assessment and intervention services furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

15. Section 414.68 is added to read as follows:

§ 414.68 Imaging accreditation.

- (a) Scope and purpose. Section 1834(e) of the Act, requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.
- (b) Definitions. As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMSdesignated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic

(i) Magnetic resonance imaging.

(ii) Computed tomography. (iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act

- (c) Application and reapplication procedures for accreditation organizations. An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:
- (1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced

diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians, such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images

produced by the supplier; and

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished.

- (2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.
- (3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.
- (4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.

(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organizations national capacity.

(iii) Description of the organizations audit procedures including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance during the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization's survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier

provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for

(B) The education, current employment and experience requirements surveyors must meet.

(C) The content and length of the

orientation program.

(ix) The frequency and types of inservice training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual

surveyors and survey teams.

(xi) The policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse

decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization's procedures for responding to and for the investigation

of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation.

(12) The accreditation organization must also submit the following supporting documentation:

(i) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(ii) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(iii) A statement acknowledging that, as a condition for approval of designation, the organization agrees to the following activities:

(A) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(B) In the case of a supplier that is accredited before January 1, 2010, the supplier must be considered accredited as of January 1, 2012.

(C) Notify CMS, in writing, of any supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.

(D) Notify all accredited suppliers within 10 calendar days of the organization's removal from the list of designated accreditation organizations.

(E) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any proposed changes in accreditation requirements.

(F) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(G) Notify CMS, in writing, (electronically or hard copy) within 2 calendar days of a deficiency identified in any accreditation supplier where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.

(H) Provide, on an annual basis, summary data specified by CMS that relates to the past years' accreditations and trends.

(I) Attest that the organization will not perform any accreditation surveys of Medicare participating suppliers with which it has a financial relationship with or interest in.

(J) Conform accreditation requirements to changes in Medicare requirements.

(iv) If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization's application for designation, the organization is notified and afforded an opportunity to provide the additional information.

(v) CMS may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff.

(vi) The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and reapplication procedures.

(d) Ongoing responsibilities of a CMS-approved accreditation organization. An accreditation organization approved by CMS must undertake the following activities on an ongoing basis:

(1) Provide to CMS all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about any supplier furnishing the TC of advanced diagnostic imaging service against which the CMS approved accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days of a change in CMS requirements, an acknowledgment of CMS' notification of the change must be submitted to CMS.

(3) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 calendar days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS' notice to a CMS approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, provide written notice of the withdrawal to all the CMS approved accreditation organization's accredited suppliers.

(6) Provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(d) Continuing Federal oversight of approved accreditation organizations. This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS approved accreditation

organization.

(1) Validation audits. CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations in the TC of advanced diagnostic imaging services. The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we would specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. At the conclusion of this audit, if CMS identifies any accreditation programs for which validation audit results

- (i) A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or its designated survey team on standards that do not constitute immediate jeopardy to patient health and safety if unmet.
- (ii) Any disparity between findings by the accreditation organization and

findings by CMS on standards that constitute immediate jeopardy to patient

health and safety if unmet.

(iii) That, irrespective of the rate of disparity, there are widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements.

(2) Notice of intent to withdraw approval. CMS provides the organization written notice of its intent to withdraw approval if an equivalency review, validation review, onsite observation, or CMS' daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) Withdrawal of approval. CMS may withdraw its approval of an accreditation organization at any time if

CMS determines that—

- (i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or
- (ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.
- (f) Reconsideration. An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) Filing requirements.

- (i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non renewal.
- (ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

- (iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.
- (2) CMS response to a filing request. In response to a request for reconsideration, CMS provides the accreditation organization with—
- (i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and
- (ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.
 - (3) Hearing requirements and rules.
- (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(1) Authorized representatives;

- (2) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and
 - (3) Legal counsel.
- (ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.
- (iii) Testimony and other evidence may be accepted by the hearing officer even though it is inadmissible under the rules of court procedures.
- (iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.
- (v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.
- (vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.
- (vii) The hearing officer's decision is final.

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

16. Section 414.402 is amended by revising the definition "Grandfathered item" to read as follows:

§ 414.402 Definitions.

* * * * *

 ${\it Grand fathered\ Item}\ {\it means\ all\ rented}$ items within a product category for

which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220

of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

17. Section 414.408 is amended by—

- (A) Redesignating paragraph (j)(5) as (j)(7).
- (B) Adding a new paragraphs (j)(5) and (j)(6).

§ 414.408 Payment rules.

* * * *

(j) * * *

(5) Notification of beneficiaries and CMS by suppliers that choose to become grandfathered suppliers.

(i) Notification of beneficiaries by

suppliers.

(Å) Requirements of notification. A noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the following requirements:

(1) Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the competitive bidding program for the CBA in which

the beneficiary resides.

(2) Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.

(3) Be in writing (for example, by letter or postcard) and the supplier must

maintain proof of delivery.

- (4) State that the supplier is willing to continue to furnish certain rented Durable Medical Equipment (DME), oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the competitive bidding program) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- (5) State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the

grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.

(6) Provide the supplier's telephone number and instruct the beneficiary to call the supplier with any questions and to notify the supplier of his or her decision to use or not use the supplier as a grandfathered supplier.

(7) State that the beneficiary can obtain information about the competitive bidding program by calling 1-800-MEDICARE or accessing http://

www.medicare.gov on the Internet.
(B) Record of beneficiary's choice. The supplier should obtain an election from the beneficiary regarding whether to use or not use the supplier as a grandfathered supplier. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. When the suppier obtains such an election, the supplier must maintain a record of the beneficiary decision including the date the choice was made, and how the beneficiary communicated his or her choice to the supplier.

(C) *Notification*. If the beneficiary chooses not to continue to receive a grandfathered item(s) from their current supplier, the supplier must provide the beneficiary with 2 more notices in addition to the 30-day notice prior to the supplier picking up its equipment.

- (1) 10-day notification: Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up. This should occur on the first anniversary date after the start of the CBP or on another date agreed to by the beneficiary or the beneficiary's caregiver. The beneficiary's anniversary date occurs every month and is the date of the month on which the item was first delivered to the beneficiary by the current supplier. When a date other than the anniversary date is chosen by the beneficiary or the beneficiary's caregiver, the noncontract supplier will still receive payment up to the anniversary date after the start of the CBP, and the new contract supplier may not bill for any period of time before the anniversary date.
- (2) 2-day notification: Two business days prior to picking up the item the supplier should contact the beneficiary of the beneficiary's caregiver by phone to notify the beneficiary of the date the supplier will pick up the item. This date

should not be before the beneficiary's first anniversary date that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(D) Pickup procedures.

- (1) The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.
- (2) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.
- (3) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary.
- (4) The contract supplier may not submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP, and the contract supplier may not begin billing until the first anniversary date that occurs after the beginning of the CBP.
- (5) The noncontract supplier must submit a claim to be paid up to the first anniversary date that occurs after the beginning of the CBP. Therefore, they should not pick up the equipment before that date unless an alternative arrangement has been made with the beneficiary and the new contract

(ii) Notification to CMS by suppliers. A noncontract supplier that elects to become a grandfathered supplier must provide a written notification to CMS of this decision. This notification must meet the following requirements:

- (A) State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the competitive bidding program) in a CBA and will continue to provide these items to these beneficiaries for the remaining months of the rental period.
 - (B) Include the following information:
 - (1) Name and address of the supplier.

(2) The 6-digit NSC number of the supplier.

 $\overline{(3)}$ Product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.

(C) State that the supplier agrees to meet all the terms and conditions pertaining to grandfathered suppliers.

(D) Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

(6) Suppliers that choose not to become grandfathered suppliers.

- (i) Requirement for non-grandfathered supplier. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification.
- (ii) Notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA.
- (iii) Requirements of notification. These notifications must meet all of the requirements listed in paragraph (j)(5)(i) of this section for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, with the following exceptions for the 30-day
- (A) State that, for those items for which the supplier has decided not to be a grandfathered supplier, the supplier will only continue to rent these competitively bid item(s) to its beneficiaries up to the first anniversary date that occurs after the start of the Medicare DMEPOS Competitive Bidding Program.

(B) State that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

(C) Refer the beneficiary to the contract supplier locator tool on http://www.medicare.gov and to 1-800-MEDICARE to obtain information about the availability of contract suppliers for the beneficiary's area.

(iv) Pickup procedures.

(A) The pick-up of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(B) Under no circumstance should a supplier pick up a rented item prior to

the supplier's receiving

acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(C) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are agreeable to the

beneficiary.

(D) The contract supplier cannot submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP.

18. Section 414.425 is added to read as follows:

§ 414.425 Claims for damages.

- (a) Eligibility for filing a claim for damages as a result of the termination of supplier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). (1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.
- (2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.
- (b) Timeframe for filing a claim. (1) A completed claim, including all documentation, must be filed within 90 days of the effective date of this paragraph, unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information

required by this rule.

(c) Information that must be included in a claim. (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, e-mail address and bidding number, and National Supplier Clearinghouse Number:

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

- (5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.
- (d) Items that will not be considered in a claim. The following items will not be considered in a claim:
- The cost of submitting a bid.
 Any fees or costs incurred for consulting or marketing.

(3) Costs associated with accreditation or licensure.

- (4) Costs incurred before March 20, 2008.
- (5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.

(6) Any profits a supplier may have expected from the contract.

- (7) Costs that would have occurred without a contract having been awarded.
- (8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.
- (9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) Filing a claim. (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for

(f) Review of claim. (1) Role of the CBIC.

(i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

- (iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and include an explanation that supports its recommendation.
- (iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.
- (A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.
- (B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;
- (v) The recommendation will be sent to the Determining Authority for a final determination.
- (2) CMS' role as the Determining Authority.
- (i) The Determining Authority shall review the recommendation of the CBIC.
- (ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.
- (iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.
- (iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.
- (v) If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

- (C) Return the claim to the CBIC with further instructions.
- (vi) The Determining Authority's determination is final and not subject to administrative or judicial review.
- (g) Timeframe for determinations. (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.
- (2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.
- (h) Notification to claimant of damage determination. The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

Subpart H—Fee Schedule for **Ambulance Services**

19. Section 414.610 is amended by revising paragraph (c)(5)(i) to read as follows:

§ 414.610 Basis of payment.

*

(c) * * * (5) * * *

(i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

Subpart J—Submission of Manufacturer's Average Sales Price

20. Section 414.802 is amended by revising the definition of "unit" to read as follows:

§ 414.802 Definitions.

Unit means the product represented by the 11-digit National Drug Code. The method of counting units excludes units of CAP drugs (as defined in § 414.902) sold to an approved CAP vendor (as defined in § 414.902) for use under the CAP (as defined in § 414.902).

Subpart K—Payment for Drugs and **Biologicals Under Part B**

§414.904 [Amended]

- 21. Amend § 414.904(d)(3) by removing the phrase "and 2009" and adding in its place the phrase "2009, and 2010.'
- 22. Section 414.906 is amended by-B. Revising the introductory text of paragraph (c) and paragraph (c)(1).
- C. Redesignating paragraph (c)(2) as
 - D. Adding new paragraph (c)(2).
- E. Adding paragraphs (f)(2)(v), (f)(3)(iv), and (g).

The revision and additions read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

- (c) Computation of payment amount. Except as specified in paragraph (c)(2) of this section, payment for CAP drugs is based on bids submitted as a result of the bidding process as described in § 414.910.
 - (1) Single payment amount.
- (i) A single payment amount for each CAP drug in the competitive acquisition area is determined on the basis of the bids submitted and accepted and updated from the bidding period to the beginning of the payment year.
- (ii) The single payment amount is then updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for that category as determined by CMS, and limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category.
- (iii) The payment amount for each other drug for which the approved CAP vendor submits a bid in accordance with § 414.910 of this subpart and each other drug that is approved by CMS for the approved CPA vendor to furnish under the CAP is also updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for each HCPCS code and limited by the payment amount established under section 1847A of the Act.
 - (2) Updates to payment amount.
- (i) The first update is effective on the first day of claims processing for the first quarter of an approved CAP vendor's contract. The first quarterly contract update is based on the reasonable net acquisition cost (RNAC) data reported to CMS or its designee for any purchases of drug before the beginning of CAP claims processing for the contract period and reported to CMS no later than 30 days before the beginning of CAP claims processing.

- (ii) For subsequent quarters, each approved CAP vendor must report to CMS or its designee RNAC data for a quarter of CAP drug purchases within 30 days of the close of that quarter.
- (iii) For all quarters, only RNAC data from approved CAP vendors that are supplying CAP drugs under their CAP contract at the time updates are being calculated must be used to calculate updated CAP payment amounts.
- (iv) CMS excludes such RNAC data submitted by an approved CAP vendor if, during the time calculations are being done, CMS knows that the approved CAP vendor will not be under contract for the applicable quarterly update.
- (v) The payment amount weights must be calculated based on the more recent of the following:
 - (A) Contract bidding weights.

(B) CAP claims data.

(vi) The payment limit must be determined using the most recent payment limits available to CMS under section 1847A of the Act.

(vii) The following payment amount update calculation must be applied for the group of all drugs for which a composite bid is required.

(A) The most recent previous composite payment amount for the

group is updated by—
(1) Calculating the percent change in reasonable net acquisition costs for each approved CAP vendor:

(2) Calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts; and (3) Limiting the payment as described

in paragraph (c)(1) of this section.

(B) The median percent change, subject to the limit described in paragraph (c)(1) of this section, must be the update percentage for that quarter.

(C) The single update percentage must be applied to the payment amount for each drug in the group of drugs for which a composite bid is required in the

- (viii) The following payment amount update calculation must be applied for each of the following items: each HCPCS code not included in the composite bid list; each HCPCS code added to the drug list during the contract period; and each drug that has not yet been assigned a HCPCS code, but for which a HCPCS code will be established.
- (A) The most recent previous payment amount for each drug must be updated by calculating the percent change in reasonable net acquisition costs for each approved CAP vendor, then calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts.
- (B) The median percent change calculated for each drug, subject to the

limit described in paragraph (c)(1) of this section, must be applied to the payment amount for each drug.

* (2) * * *

(v) On or after January 1, 2010, the proposed addition of drugs with similar therapeutic uses to drugs already supplied under the CAP by the approved CAP vendor(s).
(3) * * *

(iv) In the case of additions requested under paragraph (f)(2)(v) of this section, address and document the need for such an expansion based on demand for the product(s).

(g) Deletion of drugs on an approved CAP vendor's CAP drug list due to unavailability requires a written request and approval as described in paragraphs (f)(3)(i) through (iii) and (f)(4).

23. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as

follows:

§ 414.908 Competitive acquisition program.

(a) * * * (3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/ or sterility while being transported. *

24. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) are met; * *

25. Section 414.916 is amended by — A. Redesignating paragraph (b)(4) as (b)(5).

B. Adding new paragraph (b)(4). The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's

suspension from the program, the approved CAP vendor must cease delivery of CAP drugs to the suspended participating CAP physician until the suspension has been lifted.

*

26. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

*

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

27. Section 414.930 is amended by-

A. Revising paragraph (a). B. Redesignating paragraphs (b)(1)(v)

C. Adding new paragraphs (b)(1)(v). The revision and addition read as

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anticancer chemotherapeutic regimen.

(a) Definitions. For the purposes of

Compendium means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anticancer treatment. A compendium-

(i) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

(ii) Is indexed by drug or biological.

(iii) Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Publicly transparent process for evaluating therapies means that the following materials are available to the public on the compendium's Web site coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

- (ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.
- (iii) A listing of all individuals who have substantively participated in the development of compendia recommendations.
- (iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

Publicly transparent process for identifying potential conflicts of interests means that the following materials are identified and available to the public coincident with the compendium's publication of the related recommendation:

- (i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This includes compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations and the applicant.
- (ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

(b) * * *

(1) * * *

(v) Considers whether the publication that is the subject of the request meets the definition of a compendium in this section.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, **SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS**

28. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart D-Physician Services in **Teaching Settings**

29. Section 415.178 is revised to read as follows:

§ 415.178 Anesthesia services.

(a) General rule. (1) For services furnished prior to January 1, 2010, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.

(2) For services furnished on or after January 1, 2010, payment may be made under § 414.46(e) of this chapter if the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) Documentation. Documentation must indicate the physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

30. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

31. Section 485.70 is amended by revising paragraph (j) to read as follows:

§ 485.70 Personnel qualifications.

(j) A respiratory therapist must complete one the following criteria:

(1) Criterion 1. All of the following

must be completed:
(i) Be licensed by the State in which

practicing, if applicable.

(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists. (iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or

(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.

(2) Criterion 2: All of the following

must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare— Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: June 15, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 30, 2009.

Kathleen Sebelius,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in CY 2010. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: Alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

• An "NA" in the "Non-facility PE RVUs" column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an "NA" in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.

• Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. CPT/HCPCS code. This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at

the end of this addendum.

2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: The global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. Status indicator. This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

 $D^* = Deleted/discontinued\ code.$

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

 $F = Deleted/discontinued\ codes$. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

 H^* = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = *Not valid for Medicare purposes*. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero ((\$0.00) charge and are denied) on the MPFSDB.

N = *Non-covered service*. These codes are non-covered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = *Restricted coverage*. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of "physicians' services" for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. Description of code. This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs*. These are the RVUs for the physician work for this service in CY 2010.

6. *Nonfacility practice expense RVUs.* These are the 2010 resource-based PE RVUs for nonfacility settings.

7. Facility practice expense RVUs. These are the 2010 resource-based PE RVUs for facility settings.

8. *Malpractice expense RVUs*. These are the RVUs for the malpractice expense for the service for 2010.

Note: The budget neutrality reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

9. Global period. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply. YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra service time and in some instances in the post service time.

*Codes with these indicators had a 90-day grace period before January 1, 2005.

BILLING CODE 4210-01-P

Chron care drug investigatn Exhaled breath condensate ph

CT heart wo dye; qual calc CT heart wo dye; qual calc CT heart wo dye; qual calc

7C

TC 26

CT heart w/wo dye funct CT heart w/wo dye funct CT heart w/wo dye funct

CCTA w/wo dye CCTA w/wo dye CCTA w/wo dye

TC 26

Laparoscopic islet transplnt

Open 1slet transplant

Perq islet transplant

Conjunctival drug placement

Rbc membranes fatty acids

Scleral fistulization Chd risk imt study

CGP1*34
00987
00987
00997
01007
01007
01017
01017
01047
01147
01447
01457

Extracorp shockwy tx,hi enrg Extracorp shockwy tx,anesth

Prosth retina receive&gen

Artific diskectomy addl

Mod

Rev artific disc addl

At rest cardio gas rebreathe

Holotranscobalamin

Exerc cardio gas rebreathe

Vibrate quant sensory test Cool quant sensory test Fouch quant sensory test

Heat quant sensory test Nos quant sensory test

Proposed Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010 ADDENDUM B:

	Slobal	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XX	XXX	XXX	XXX	XXX
Mal- Practice	Ī															0.00						00.0	٠								0.00					0.00	000	0.00
Facility	RVUs ^{2,3}	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	Ϋ́	NA	0.00	0.00	0.00	0.00	0.00	0.00	NA	ΝA	NA	0.00	NA	NA	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Non- Facility PF	RVUs ^{2,3}	0.00	0.00	0.00	000	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	000	0.00	0.00	0.00	0.00	0.00	7.98	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Physi- cian Work	RVUs ^{2,3}	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Description	Thermotx choroid vasc lesion	Photocoagulat macular drusen	Extracorp shock wy tx,ms nos	Antiprothrombin antibody	Ct perfusion w/contrast, cbf	Implant ventricular device	Removal circulation assist	Implant total heart system	Replace component heart syst	Replace component heart syst	Bone surgery using computer	Bone surgery using computer	Spectroscop eval expired gas	Ct colonography;dx	Ct colonography;dx	Ct colonography;dx	Interp/rept heart sound	Analysis only heart sound	Interp only heart sound	U/s leiomyomata ablate <200	U/s letomyomata ablate >200	Delivery, comp unit	Perq stent/chest vert art	Perq stent/chest vert art	Perq stent/chest vert art	S&1 stent/chest vert art	S&1 stent/chest vert art	S&1 stent/chest vert art	Cereb therm perfusion probe	Endovase aort repr w/device	Endovasc visc extnsn repr	Endovase aort repr rad s&1	Endovase vise extnsn s&1	Temp prostate urethral stent	L ventricle fill pressure	Sperm eval hyaluronan	Artific disc addl
	Status	ပ	ပ	ပ	ပ	ပ	၁	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	ပ	Ą	၁	ပ	၁	ပ	၁	၁	ပ	၁	ပ	ပ	ပ	ပ	ပ	Ö	ပ
	Mod															TC	56								TC	56		TC	56									
CPT ^{1,3} /	HCPCS	T9100	0017T	T6100	0030T	0042T	0048T	T0500	0051T	0052T	0053T	0054T	0055T	0064T	TL900	TC900	TC900	T8900	T6900	T0700	0071T	0072T	0073T	T2700	12700	T2700	T9700	T9700	T9700	17700	T8700	T6700	T0800	0081T	0084T	T9800	0087T	0092T

CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights

Mark 1, 1978, Ma CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Parally Selection (1998)

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Selection (1998) CCTA w/wo, strxr quan calc CCTA w/wo, disease strxr TC 26 0148T 0148T 0148T 0149T 0149T 0150T

CCTA w/wo, strxr quan calc CCTA w/wo, strxr quan calc

CCTA w/wo, strxr

TC 26

CCTA w/wo, quan calcum CCTA w/wo, quan calcum

CCTA w/wo, quan calcum

TC 26

CCTA w/wo, strxr CCTA w/wo, strxr

established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chargractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding. If values are reflected for codes not payable by Medicare, please note that these values have been

² If values are reflected for codes not payable by Medicare, please note that these values have been restabilisted as a courtesy to the general public and are not used for Medicare payment.
³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for

Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.

CDT ^{1,3} ,				Physi- cian Work	Non- Facility PE	Facility	Mal- Practice		l _{e1} .1d5			Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	
HCPCS	Mod	Status	Description	RVUs.3	RVUs ^{2,3}	RVUs.3	RVUs ^{2,3,4}	Global	Mod St		Description	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3,4}	Global
0150T	JC	ပ	CCTA w/wo, disease strxr	000	0.00	NA S	0.00	XXX			Kt bladder neck microremodel	0.00	0.0	900	900	4
0150T	56	ပ	CCTA w/wo, disease strxr	0.00	0.00	000	0.00	XXX	01941 C		rocalcitonin (pet)	0.00	0.00	000	0.00	XX
0151T		ပ	CT heart funct add-on	0.00	00	NA	000	XXX	0195T C	٠.	Arthrod presac interbody	0.00	0.00	0.00	0.00	X
0151T	TC	ပ	CT heart funct add-on	0.00	0.00	ΝΑ	000	XXX	0196T	٠,	Arthrod presac interbody eac	0.00	0.00	000	0.00	X
0151T	56	ပ	CT heart funct add-on	000	0.00	0.00	0.00	XXX	0197T C	'	intrafraction track motion	0.00	0.00	000	0.00	XX
0155T		ပ	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	XXX	O1981 C	_	Ocular blood flow measure	0.00	0.00	0.00	0.00	X .
0156T		ပ	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	XXX	0528F I	<u>~</u>	Remnd flw-up 10 yrs doed	0.00	0.00	0.00	0.00	XX
0157T		ပ	Open unpl gast curve electrd	0.00	0.00	0.00	000	XXX	0535F I	Н	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	XX
0158T		ပ	Open remy gast curve electrd	0.00	0.00	0.00	0.00	XXX	0575F I	14	HIV ma plan care docd	000	0.00	0.00	0.00	XXX
0159T		ပ	Cad breast mri	0.00	0.00	NA	0.00	ZZZ	10021 A	щ	na w/o mage	1.27	2.33	0.52	0.11	XXX
0159T	IC	ပ	Cad breast mri	0.00	000	ΝΑ	0.00	ZZZ	10022 A	щ	Fna w/unage	1.27	5.09	0 42	60.0	XXX
0159T	56	ပ	Cad breast mri	0.00	000	0.00	0.00	ZZZ	10040 A	•	Acne surgery	1 19	1.36	1 05	0.07	010
0160T		ပ	Tcranial magn stim tx plan	0.00	0.00	000	0.00	XXX	I0060 A	н	Dramage of skm abscess	1.19	1.69	1 22	80.0	010
0161T		၁	Teranial magn stim tx deliv	0.00	0.00	000	0.00	XXX			Dramage of skm abscess	2.42	2.32	171	0.19	010
0163T		O	Lumb artif diskectomy addl	0.00	0.00	000	0.00	YYY			Dramage of pilonidal cyst	1.19	3.08	1 33	0.11	010
0164T		O	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	YYY	10081 A		Dramage of pilonidal cyst	2.47	4.19	1.85	0.28	010
0165T		O	Revise lumb artif disc addl	0.00	0.00	00 0	0.00	YYY			Remove foreign body	1.23	2.29	1.14	60.0	010
T9910		C	Teath vsd close w/o bypass	0.00	0.00	0.00	0.00	XXX	10121 A		Remove foreign body	2.71	4.05	1.95	0.28	010
T7910		C	Teath vsd close w bypass	00 0	0.00	0.00	0.00	XXX	10140 A		Dramage of hematoma/fluid	1.55	2.49	1 43	0.14	010
0168T		Ö	Rhmophototx light app bilat	00 0	0.00	0.00	0.00	XXX			Puncture dramage of lesson	1.22	2.03	1 20	0 11	010
T6910		Ü	Place stereo cath brain	0.00	0.00	00 0	0.00	XXX		•	Complex dramage, wound	2.27	3.74	2.12	0.34	010
0170T		Ü	Anorectal fistula plug ror	0.00	0.00	0.00	0.00	XXX	11000 A	,	Debride infected skin	09:0	0.78	0.17	0.04	000
0171T		Ü	Lumbar spine proces distract	0.00	0.00	0.00	0.00	XXX	11001 A	_	Debride infected skin add-on	0.30	0 25	60.0	0.02	ZZZ
0172T		ڻ ان	Lumbar spine process addl	0.00	0.00	0.00	0.00	XXX			Debride genitalia & perineum	10.80	NA	3.91	1.40	000
0173T		Ü	Iop monit to pressure	0.00	0.00	0.00	0.00	XXX			Debride abdom wall	14 24	NA	5.35	2.21	000
0174T		Ö	Cad cxr with interp	0.00	0.00	0.00	0.00	XXX	11006 A	-	Debride genit/per/abdom wall	13.10	NA	4.82	1.72	000
0175T		ပ	Cad cxr remote	0.00	0.00	0.00	0.00	XXX	11008 A		Remove mesh from abd wall	5.00	NA	1.88	0.79	ZZZ
19710		ပ	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	XXX		_	Debride skin, fx	4.19	8.01	2.91	0.56	010
0177T		၁	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	XXX			Debride skin/muscle, fx	4.94	8.21	2.63	0.70	000
0178T		ပ	64 lead ecg w 1&r	0.00	0.00	000	0.00	XXX	11012 A		Debride skin/muscle/bone, fx	6.87	10.64	3.89	66.0	000
16710		ပ	64 lead ecg w tracing	0.00	0.00	0.00	0.00	XXX	11040 A		Debride skin, partial	0.50	0.73	0 16	0.03	000
0180T		ပ	64 lead ecg w 1&r only	0.00	0.00	0.00	0.00	XXX		_	Debride skm, full	09:0	0.78	0 2 0	0.04	000
0181T		ပ	Corneal hysteresis	0.00	0.00	0.00	0.00	XXX			Debride skin/tissue	080	1.09	0.29	0.07	00
0182T		ပ	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	XXX	11043 A	_	Debride tissue/muscle	3.04	4.10	3.08	0.34	010
0183T		ပ	Wound ultrasound	0.00	0.00	0.00	0.00	XXX	11044 A	П	Debride tissue/muscle/bone	4.11	5.72	4.28	0.53	010
0184T		ပ	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	XXX	11055 R	_	frim skin lesion	0.43	98.0	0 11	0.02	000
0185T		ပ	Comptr probability analysis	0.00	0.00	0.00	0.00	XXX	11056 R	_	Frim skm lesions, 2 to 4	0.61	0.93	0.15	0.03	000
0186T		ပ	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	XXX	11057 R	_	Frim skin lesions, over 4	0.79	1.04	0.19	0.04	000
0187T		ပ	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	XXX	11100 A	щ	Biopsy, skin lesion	0.81	1.77	0.48	0.05	00
0190T		ပ	Place intraoc radiation src	0.00	0.00	0.00	0.00	XXX	11101 A	щ	Biopsy, skin add-on	0.41	0.43	0.24	0.02	ZZZ
0191T		Ö	Insert ant segment dram int	0.00	0.00	0.00	000	XXX	11200 A	24	Removal of skm tags	0.79	1.35	1.01	0 05	010
0192T		ပ	Insert ant segment dram ext	0.00	0.00	0.00	0.00	XXX	11201 A	-	Remove skin tags add-on	0.29	0.20	0.15	0.02	ZZZ
	1 CPT oc	odes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	тепсап Мед	ıcal Associa	tion. All Ru	zhts		' CPT codes au	and de	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medic	al Associati	on. All Rıg	ıts	
	Reserved.	ij							Reserved.				7	-		
	' If value	es are re	It values are reflected for codes not payable by Medicare, please note that these values have been	re, please no	te that these	values have	peen		It values are	retlec	" It values are reflected for codes not payable by Medicare, please note that these values have been setablished as a confrest to the senaral miblic and are not used for Medicare payment.	re, please note	mat mese va	alues nave o	een	
	3 The bu	idget neu	estabilistica as a courtesy to the general public and action used for interesting payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	lemonstration	is not reflec	ted in the R	VUs for CPT		³ The budget n	neutra	The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT	emonstration 1	s not reflect	ed in the RV	Us for CPT	
	codes 98	8940, 989	codes 98940, 98941, and 98942. The required reduction will only be reflected	will only be	reflected in	in the files used for	1 for		codes 98940, 9	98941	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be re	eflected m th	e files used	for	
	Medicar	Medicare payment	int.	-					Medicare payment.	ment.	Medicare payment.	out passed				
	Clobal	totals to	Global totals for mapractice K VUS may not sum due to rounding	o rounding.					CIODALIOIAIS	I IOI S	iaipiactice KVOS may not sum due to	o rounding.				

1.55 C.2.7 C.2.0 C.2.0	CPT ^{1,3} /				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice		CPT ^{1,3} /		:	Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	
1959 1 A Exc best difference 1,155 1 A Exc best difference 1,155 1 A Exc best difference 1,155 1				ription	RVUs"	RVUs	RVUs.	RVUs'	Global			Description	RVUs~	RVUs⁻⁻	KVUs-	KVUs-::	Global
1600 A Exc rest injuring (3.5 cm) 1500 1500 16		¥			0.51	1.23	0.27	0.03	000	1159F	-	Med list docd in rerd	0.00	0.00	0.00	0.00	X 8
000 11601 A Exe extangivage (3-1) and 2.02 3.89 173 0.15 0.16 0.00 0.00 11601 A Exe extangivage (3-1) and 2.02 3.89 191 0.16 0.16 0.00 0.00 0.16 0.16 0.16 0.1		¥		-	0.85	1 20	0.48	0.05	000	11600	V	Exc tr-ext mig+marg 0.5 < cm	1.58	3.07	1.58	710	010
000 11662 A Extract migrange 1-1-3 cm 22.7 3.88 191 0.16 000 11669 A Extract migrange 3-1-4 cm 22.7 3.88 191 0.16 000 11664 A Extract migrange 3-1-4 cm 21.7 4.82 2.90 0.28 000 11664 A Extract migrange 3-1-4 cm 40.7 61.7 3.10 0.56 000 11669 A Extract migrange 3-1-4 cm 40.7 61.7 3.10 0.58 000 11621 A Extract migrange 3-1-4 cm 40.7 61.7 10.2 0.00 11623 A Extract migrange 3-1-4 cm 40.7 61.7 61.7 61.7 61.7 11624 A Extract migrange 3-1-4 cm 40.7 43.8 2.5 5.2 6.0 1164 A Extract migrange 3-1-4 cm 40.7 43.8 2.3 6.1 6.0 1164 A Extract migrange 3-1-4 cm 43.7 43.9 2.3 6.1 6.0 1164 A Extract feeting migrange 4-1-4 cm		V			1.05	1 74	090	900	000	11601	V	Exc tr-ext mlg+marg 0.6-1 cm	2.02	3.59	1.73	0.15	010
1603 A Exer-ext milg-marg 1.1-3 m 2.77 4.62 2.17 0.22		A			1.24	2 04	0.70	80.0	000	11602	A	Exc tr-ext mlg+marg 1 1-2 cm	2.22	3.88	161	0.16	010
1604 A Exe text milg-mag 3,14 cm 312 513 528		V			0.67	113	0.22	0 04	000	11603	A	Exc tr-ext mlg+marg 2.1-3 cm	2.77	4 22	2 17	0.22	010
11606 A Exc ber ext might mang 3 ct and 4.97 of 51 0 0.00 116100 A Exc be-fack-go might mang 0.4 150 0.00 11620 A Exc be-fack-go might mang 0.4 150 0.00 11621 A Exc be-fack-go might mang 0.4 150 0.00 11622 A Exc be-fack-go might mang 0.4 150 0.00 11623 A Exc be-fack-go might mang 0.4 150 0.00 11624 A Exc be-fack-go might mang 0.4 150 0.00 11625 A Exc be-fack-go might mang 0.4 150 0.00 11626 A Exc be-fack-go might mang 0.4 150 0.00 11627 A Exc be-fack-go might mang 0.4 150 0.00 11628 A Exc be-fack-go might mang 0.4 150 0.00 11629 A Exc be-fack-go might mang 0.4 150 0.00 11641 A Exc face-mun manight mang 0.5 162 0.00 11642 A Exc face-mun manight mang 0.5 162 0.00 11643 A Exc face-mun manight mang 0.4 150 0.00 11644 A Exc face-mun malgit mang 0.4 150 0.00 11655 A Exc face-mun malgit mang 0.4 150 0.00 11656 A Exc face-mun malgit mang 0.4 150 0.00 11670 A Exc face-mun malgit mang 0.4 150 0.00 11720 A Exc face-mun malgit mang 0.4 100 0.00 11720 A Exc face-mun malgit mang 0.4 100 0.00 11720 A Exc face-mun malgit mang 0.4 100 0.00 11720 A Exc face-mun malgit mang 0.4 100 0.00 11721 A Derich mal 1.5 0.2 0.40 0.00 11720 A Removal of mul pate 0.01 0.01 11720 A Removal of mul bate 0.01 0.00 11721 A Removal of mul bate 0.01 0.00 11722 A Removal of mul bate 0.01 0.00 0.00 11723 A Removal of mul bate 0.01 0.00 0.00 11724 A Removal of mul bate 0.00 0.00 0.00 11725 A Removal of mul bate 0.00 0.00 0.00 11726 A Removal of mul bate 0.00 0.00 0.00 11727 A Removal of mul bate 0.00 0.00 0.00 11728 A Removal of mul bate 0.00 0.00 0.00 11729 R Removal of mul bate 0.00 0.00 0.00 11720 A Removal of m		Y			0.99	1 46	0 43	90 0	000	11604	A	Exc tr-ext mlg+marg 3.1-4 cm	3 12	4 63	2 30	0.28	010
000 1160F 1 Rev h-Fake sping marged 5- 1.95 3.13 1.42 0.00 0.00 000 11620 A Exc h-Fake sping marged 5- 1.95 3.13 1.42 1.95 0.15 000 11621 A Exc h-Fake sping marged 5-1 2.05 3.66 1.95 0.15 010 11623 A Exc h-Fake sping marged 1-1 2.05 3.62 1.76 0.15 010 11624 A Exc h-Fake sping marged 1-1 2.05 3.96 1.93 0.10 010 11624 A Exc h-Fake sping marged 1-1 3.57 4.35 2.35 0.50 0.50 010 11644 A Exc face-mm malger marged 1-1 2.17 4.18 1.19 0.00 010 11644 A Exc face-mm malger marged 1-1 2.17 4.18 2.11 0.00 010 11644 A Exc face-mm malger marged 1-1 4.29 5.59 2.51 0.01 010		¥		r.	1.14	1 73	0 57	0.07	000	11606	Ą	Exc tr-ext mlg+marg > 4 cm	4.97	6.17	3 10	0.56	010
000 11620 A Exc b-Felicks pmigramage 0.4 1.59 3.62 1.79 0.15 000 11621 A Exc b-Felicks pmigramage 0.1 2.03 36.2 1.76 0.15 000 11622 A Exc b-Felicks pmigramage 1.1.2 2.03 3.05 1.78 0.17 010 11623 A Exc b-Felicks pmigramage 1.1.2 2.04 4.39 2.32 0.34 010 11643 A Exc b-Felicks pmigramage 1.1.2 3.06 1.88 0.17 010 11640 A Exc becomm malgramage 0.4 1.21 3.05 1.29 0.30 010 11642 A Exc becomm malgramage 0.4 1.21 3.04 1.83 0.01 010 11643 A Exc becomm malgramage 0.4 4.29 2.21 0.30 010 11644 A Exc becomm malgramage 1.1.3 3.74 4.18 0.01 010 11644 A Exc becomm malgramage 1.1.3 4.29 5.91 0.30 010 11644 A Exc becomm malgramage 1.1.3 4.29 6.71		A		ı.	1.41	1 79	0.56	80 0	000	1160F	н	Rvw meds by rx/dr in rcrd	0.00	0.00	000	000	XXX
000 11621 A Exc b-Felk-sp mig-marg 0-1 2.03 562 176 0.15 000 11622 A Exc b-Felk-sp mig-marg 1.1-2 2.56 3.96 1.98 0.17 000 11623 A Exc b-Felk-sp mig-marg 1.1-3 2.65 3.96 1.98 0.17 010 11624 A Exc b-Felk-sp mig-marg 1.1-3 3.67 4.89 2.92 0.50 010 11640 A Exc be-cam malg-marg 1.1-3 3.74 4.83 2.93 0.04 010 11641 A Exc face-mm malg-marg 1.1-3 2.77 4.15 2.11 0.00 010 11642 A Exc face-mm malg-marg 1.1-3 2.77 4.15 2.11 0.00 010 11643 A Exc face-mm malg-marg 1.1-3 3.74 4.39 2.93 0.04 010 11646 A Exc face-mm malg-marg 1.1-4 4.20 5.94 2.91 0.01 010 1170 A Exc face-mm malg-marg 1.1-4 4.20 5.94 2.95 0.04 010 1170		¥		n	0.73	1.40	0.40	0 0	000	11620	A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	3.13	1.42	0 12	010
1622 A Exc b-f-kes pulg-rang 1.1-2 3.6 3.96 1.08 0.17		Y		п	1.05	1.64	090	0.07	000	11621	A	Exc h-f-nk-sp mlg+marg 0.6-1	2.03	3.62	1 76	0.15	010
000 11623 A Exc b-Fack-sp migramg 2.1-3 3.06 4.39 2.22 0.35 010 11624 A Exc b-Fack-sp migramg 3.1-4 3.7 4.83 2.92 0.34 010 11640 A Exc face-mm malg-rmag 0.4- 1.62 5.99 2.92 0.50 010 11641 A Exc face-mm malg-rmag 0.4- 1.12 3.74 4.18 0.16 010 11643 A Exc face-mm malg-rmag 0.4- 2.27 4.18 2.99 0.61 010 11644 A Exc face-mm malg-rmag 0.4- 2.77 4.18 2.99 0.61 010 1164 A Exc face-mm malg-rmag 0.1- 2.17 4.99 2.21 0.05 010 1179 B Exc face-mm malg-rmag 0.1- 2.17 4.99 2.91 0.01 010 1179 A Exc face-mm malg-rmag 0.1- 2.17 4.90 0.01 0.01 010 1171 A Exc face-mm malg-rmag 0.1-		4		п	1.20	1 90	0 70	800	000	11622	A	Exc h-f-nk-sp mlg+marg 1.1-2	2.36	3.96	86 1	0.17	010
10.00 116.02 A Exc b-Fak-sp mig-rmang 3.1-4 5.5 5.59 5.34		V		p	1.62	2.24	0.92	0 11	000	11623	A	Exc h-f-nk-sp mlg+marg 2.1-3	3.06	4.39	2.32	0.26	010
11626		A		arg 0.5 < cm	0.87	2.11	1.10	0 0 0	010	11624	A	Exc h-f-nk-sp mlg+marg 3.1-4	3.57	4.83	2 53	0.34	010
11640		¥	_	arg 0.6-1 cm	1.25	2.38	1.33	0.10	010	11626	A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	5.59	2.92	0.50	010
010 11641 A Exc face-mm mally-mang 0.6-1 21.2 3.74 1.83 0.16 010 11642 A Exc face-mm mally-mang 0.1-3 3.77 4.15 2.51 0.30 010 11643 A Exc face-mm mally-mang 3.1-3 4.29 5.54 2.99 0.41 010 11646 A Exc face-mm mally-mang 3.1-3 4.29 5.54 2.99 0.41 010 11730 A Exc face-mm mally-mang 3.1-4 4.29 5.54 2.99 0.41 010 11720 A Exc face-mm mally-mang 3.1-4 4.29 5.54 2.99 0.41 010 11720 A Debrids mall 1.5 0.17 0.49 0.08 0.02 010 11720 A Removal of pala 4 0.77 0.57 0.13 0.03 0.03 0.03 0.03 0.03 0.04 0.03 0.03 0.04 0.03 0.04 0.03 0.04 0.03 0.04 0.03 0.04<		¥		arg 1.1-2 cm	1.42	2.61	1.41	0.13	010	11640	A	Exc face-mm malg+marg 0.5 <	1.62	3.26	1.50	0.13	010
010 11642 A Exc face-mm malig+marg 1.1-2 2.57 4.15 2.11 0.20 010 11644 A Exc face-mm malig+marg 2.1-3 3.37 4.59 2.51 0.30 010 11644 A Exc face-mm malig+marg 2.1-3 3.37 4.59 2.51 0.04 010 11719 R Trum nation 0.17 0.40 0.04 0.01 010 11719 R Trum nation 0.17 0.40 0.04 0.01 010 11720 A Debride anal, 6 or nore 0.54 0.57 0.04 0.01 010 11720 A Removal of nation for all and to 0.57 0.55 0.14 0.03 010 11730 A Removal of nation for all and to 0.57 0.56 0.44 0.03 010 11730 A Removal of pointed from under nation 0.57 0.56 0.44 0.03 010 1172 A Removal of nation for the or 0.34 0.40 0.14		¥		arg 2.1-3 cm	1.81	2.87	1.84	0.18	010	11641	A	Exc face-mm malig+marg 0.6-1	2.12	3.74	1.83	0.16	010
11643		¥		arg 3.1-4 cm	2.08	3.25	1.96	0 22	010	11642	A	Exc face-mm malig+marg 1.1-2	2.57	4.15	2 11	0 2 0	010
010 11644 A Exc face-mm malge-mang 3.1-4 4.29 5.54 2.99 0.41 010 11666 A Exc face-mm malge-mang 3.1-4 6.21 6.72 3.99 0.41 010 11720 A Debrade mal, 1-5 0.32 0.49 0.08 0.01 010 11720 A Debrade mal, 6 or more 0.54 0.57 0.13 0.03 010 11731 A Remove nal plate, add-on 0.57 0.57 0.14 0.05 010 11732 A Remove nal plate, add-on 0.57 0.85 0.44 0.03 010 11732 A Remove nal plate, add-on 0.57 0.85 0.44 0.03 010 11752 A Remove nal plate, add-on 0.57 0.85 0.44 0.03 010 11752 A Removal of null mal contract add-on 0.57 0.85 0.14 0.03 010 11752 A Removal of null mal contract add-on		V		arg > 4.0 cm	3.47	4.16	2.60	0.45	010	11643	Ą	Exc face-mm malig+marg 2.1-3	3.37	4.59	2.51	0.30	010
010 11646 A Exc face-mm mlg+rmarg > 4 cm 6.21 6.72 3.95 0.63 010 11719 R Trum nal(s) 0.17 0.49 0.04 0.01 010 11720 A Debride and, 1-5 0.53 0.49 0.08 0.02 010 11720 A Debride and, 6 or more 0.54 0.57 0.13 0.03 010 11730 A Removal of nall plate 1.10 1.41 0.27 0.06 0.05 010 11732 A Removal of nall bad 2.40 3.68 0.46 0.02 010 11752 A Removal of nall bed 2.40 3.64 0.07 0.14 0.02 010 11752 A Removal of nall bed 2.40 3.44 0.49 0.07 010 11752 A Removal of nall bed 2.41 1.47 0.49 0.07 010 11752 A Removal of nall bed 1.24		Y		1+marg 0.5 <	1.00	2.02	1.05	0.07	010	11644	A	Exc face-mm malig+marg 3.1-4	4.29	5.54	2 99	0.41	010
11719 R Trum nail(s) 0.17 0.40 0.04 0.01 11720 A Debrude nail, 1-5 0.54 0.57 0.49 0.08 0.02 11721 A Debrude nail, 1-5 0.54 0.57 0.57 0.05 0.03 11722 A Removal of nail plate 1.10 1.41 0.27 0.05 11723 A Removal of nail plate 1.10 1.41 0.27 0.05 11724 A Dram blood from under nail 0.37 0.57 0.57 0.04 0.00 11725 A Removal of nail bed 2.40 3.16 1.99 0.14 11725 A Removal of nail bed 1.50 3.16 1.99 0.14 11726 A Removal of nail bed 1.60 4.06 1.73 0.17 010 11725 A Removal of nail bed 1.60 4.06 1.73 0.17 010 11726 A Removal of nail bed 1.60 4.06 1.73 0.17 010 11727 A Removal of nail bed 2.40 3.16 1.99 0.04 020 1170 A Removal of nail bed 2.63 4.11 1.92 1.80 030 1170 A Removal of pilonidal lesion 2.63 4.11 1.92 0.37 030 1171 A Removal of pilonidal lesion 2.63 4.11 1.92 0.37 030 1172 A Removal of pilonidal lesion 2.63 4.11 1.92 0.37 030 1170 A Removal of pilonidal lesion 2.63 0.05 0.05 030 1170 A Removal of pilonidal lesion 2.63 0.05 0.05 030 1170 A Removal of pilonidal lesion 0.00 0.00 0.00 030 1180F A Added skin lesions 0.52 0.89 0.31 0.05 030 Axxx 11920 R Correct skin color defects 1.93 3.06 1.54 0.22 030 Axxx 11920 R Correct skin color defects 0.49 1.05 0.54 0.55 031 Axistrate payment 1.00 0.00 0.00 0.00 032 Axistrate payment 1.00 0.00 0.00 0.00 034 Axistrate payment 1.00 0.00 0.00 0.00 035 0.05 0		A		1+marg 0.6-1	1.44	2.42	1.33	0.12	010	11646	A	Exc face-mm mlg+marg > 4 cm	6.21	6.72	3 95	0.63	010
010 11720 A Debride nail, 1-5 0.32 0.49 0.08 0.02 010 11721 A Debride nail, 6 or more 0.54 0.57 0.13 0.06 010 11730 A Removal of nail plate 1.10 1.14 0.27 0.03 010 11730 A Removal of nail plate, add-on 0.57 0.57 0.14 0.03 010 11730 A Removal of nail bed 2.40 3.16 1.99 0.14 010 11752 A Removal of nail bed 2.40 3.16 1.99 0.14 010 11752 A Removal of nail bed 1.91 4.47 3.04 0.28 010 1176 A Repart of nail bed 1.91 4.47 3.04 0.28 090 1176 A Reconstruction of nail bed 2.91 4.47 3.04 0.28 090 1177 A Reconstruction of nail bed 2.91 4.91		¥	,	1.1-2 h+marg	1.65	2.65	1.73	0.15	010	11719	×	Trum naıl(s)	0.17	0.40	0.04	0.01	000
11721		A		1+marg 2.1-3	2.03	2.96	1.91	0.20	010	11720	A	Debride nail, 1-5	0.32	0.49	80.0	0.02	000
1130		A	_	3.1-4 harg 3.1-4	2.45	3.31	5.06	0.26	010	11721	¥	Debride nail, 6 or more	0.54	0.57	0.13	0.03	000
1172		Y		1+marg > 4 cm	4.04	4.16	2.80	0.47	010	11730	¥	Removal of naıl plate	1.10	1.41	0.27	90.0	000
11740		A	_	+marg 0.5 < cm	1.02	2.24	1.52	0.07	010	11732	∢	Remove naıl plate, add-on	0.57	0.57	0 14	0.03	ZZZ
11750 A Removal of nail bed 2.40 3.16 1.99 0.14 11751 A Removal of nail bed 2.40 3.16 1.99 0.14 11752 A Remove nail bodfinger tip 3.48 4.17 3.04 0.28 11760 A Repair of nail bed 1.60 4.06 1.73 0.17 11760 A Reconstruction of nail bed 1.50 4.19 1.89 0.021 11761 A Removal of pulondal lesson 2.63 4.11 1.92 0.37 11771 A Removal of pulondal lesson 5.98 8.03 4.69 0.03 11772 A Removal of pulondal lesson 5.63 4.11 1.92 0.37 090 11772 A Removal of pulondal lesson 5.63 4.11 1.92 0.37 090 11772 A Removal of pulondal lesson 5.63 8.03 4.69 0.00 000 11772 A Removal of pulondal lesson 5.03 8.03 4.69 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 000 000 0.00 0.00 0.00 000 000 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 0.00 000 0.00 0.00 000 0.00 0.00 000 0.00 0.00 000 0.00 0.		Y		+marg 0.6-1 cm	1.50	2.61	1.77	0.13	010	11740	A	Dram blood from under naul	0.37	98.0	0.46	0.02	000
1175		A		+marg 1.1-2 cm	1.74	2.88	1.89	91.0	010	11750	¥	Removal of nail bed	2.40	3.16	1.99	0.14	010
1175		Y		+marg 2.1-3 cm	2.31	3 22	2.16	0.22	010	11752	¥	Remove nail bed/finger tip	3.48	4.47	3.04	0.28	010
11760		V		+marg 3.1-4 cm	3.16	3.81	2.57	0.30	010	11755	¥	Biopsy, nail unit	1.31	2.14	080	0.07	00
1762		A	_	+marg > 4 cm	4.75	4.91	3.43	0.47	010	11760	¥	Repair of nail bed	1.60	4 06	1 73	0.17	010
1765 A Receion of faul fold, toe 0.71 2.88 107 0.04 1771 A Removal of plontidal lesson 5.98 8.03 4.69 0.92 1771 A Removal of plontidal lesson 5.98 8.03 4.69 0.92 1772 A Removal of plontidal lesson 7.23 9.66 6.87 1.09 1772 A Removal of plontidal lesson 7.23 9.66 6.87 1.09 180F I Thromboendh risk assessed 0.00 0.00 0.00 180F A Injection mito skin lessons 0.52 0.89 0.31 0.03 XXX 11920 A Added skin lessons mjection 0.80 1.00 0.48 0.04 XXX 11920 R Correct skin color defects 1.93 3.06 1.54 0.28 XXX 11922 R Correct skin color defects 1.93 3.06 1.54 0.28 XXX 11922 R Correct skin color defects 0.49 1.05 0.55 0.05 XXX 11922 R Therapy for contour defects 0.84 1.06 0.55 0.05 CPT codes and descriptions only are copyright 2009 American Medical Association All Rights Reserved 2 The values are reflected for codes not payable by Medicare, please note that these values have been established as a coursety to the general public and are not used for Medicare payment. 3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the files used for Medicare payment. 4 Coloral totals for mathracter RV15 may not sum due to rounding		A	1 Removal, sweat §	gland lesion	3.14	6 05	3.00	0.47	060	11762	V ·	Reconstruction of nail bed	2.91	4.19	1.89	0.22	010
1770		A	Removal, sweat g	gland lesion	4.35	737	3.58	99.0	060	11765	V	Excision of nail fold, toe	0.71	2.88	1.07	0.04	010
1771		A	A Removal, sweat g	gland lesion	2.92	91.9	3.01	0.43	060	11770	∢ ·	Removal of pilonidal lesion	2.63	4.11	1 92	0.37	010
17/12		¥	Removal, sweat g	gland lesion	4.35	7.59	3.66	0 64	060	11771	∢ ·	Removal of pilonidal lesion	5.98	8.03	60.4	0.92	060
180F 1 Immobosomb risk assessed 0.00 0.00 0.00 0.00 180F 1 Immobosomb risk assessed 0.05 0.00 0.00 0.00 0.00 0.00 180F 1 Immobosomb risk assessed 0.05 0.00 0.00 0.00 0.00 190B A Added skin lesons injection 0.80 1.00 0.48 0.04 192D R Correct skin color defects 1.61 2.68 1.34 0.22 180C R Correct skin color defects 1.61 2.68 1.34 0.22 192D R Correct skin color defects 0.49 1.05 0.28 192D R Therapy for contour defects 0.84 1.06 0.55 0.05 192D R Therapy for contour defects 0.84 1.06 0.55 0.05 192D R Therapy for contour defects 0.84 1.06 0.55 0.05 192D R Therapy for contour defects 0.84 1.06 0.55 0.05 192D R Therapy for contour defects 0.84 1.05 0.28 192D R Therapy for contour defects 0.84 1.05 0.55 0.05 192D R Therapy for contour defects 0.84 1.05 0.55 0.05 192D R Therapy for contour defects 0.84 1.05 0.55 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05 192D R Therapy for contour defects 0.84 1.05 0.05		¥	Removal, sweat g	gland lesion	3.66	6.40	3.27	0.53	060	11772	∢ ·	Removal of pilonidal lesion	7.23	996	6.87	1.09	060
1900		A	Removal, sweat g	gland lesion	18.1	7 59	3.79	89.0	060	1180F	-	I hromboemb risk assessed	0.00	0.00	000	0.00	X 8
1901		_	Doc pt rsk death	w/m lyr	0.00	0.00	0.00	000	XXX	11900	∢ ·	Injection into skin lesions	0.52	0.89	0.31	0.03	000
XXX 11920 R Correct skin color defects 1.61 2.68 1.34 0.22 XXX 11921 R Correct skin color defects 1.93 3.06 1.54 0.28 XXX 11922 R Therapy for contour defects 0.49 1.05 0.28 0.07 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 XXX 11920 R Therapy for contour defects 0.84 1.06 0.55 0.05 Reserved. 2 If values are reflected for codes not payable by Medicare payment. 2 If values are reflected for codes not payable by Medicare payment. 2 If values are reflected for codes not paya		1	Doc no pt rsk dea	ath w/m 1yr	0.00	0.00	0.00	0.00	XXX	11901	V	Added skin lesions injection	0.80	00.	0.48	0.04	000
XXX 11921 R Correct skin color defects 1.93 3.06 154 0.28 XXX 11922 R Correct skin color defects 1.93 3.06 154 0.07 XXX 11950 R Therapy for contour defects 0.84 1.06 0.55 0.07 XXX 11950 R Therapy for contour defects 0.84 1.06 0.55 0.05 CPT codes and descriptions only are copyright 2009 American Medical Association All Rights Reserved. 2 Trailues are reflected for codes not payable by Medicare, please note that these values have been established as a courtey; for the general public and are not used for Medicare payment. 3 The budget neutrality reduction from the chrospactic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. 4 Clobal totals for main-action RVUs may not sim due to roundine.		I	Doc advncd dis c	comfort 1st	0.00	0.00	0.00	000	XXX	11920	×	Correct skin color defects	1.61	2.68	1 34	0.22	000
XXX 11922 R Correct skin color defects 0.49 1.05 0.28 0.07 XXX 11950 R Therapy for contour defects 0.84 1.06 0.55 0.05 11950 Reserved. 1 CPT codes and descriptions only are copyright 2009 American Medical Association All Rights Reserved. 2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. 3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the files used for Medicare payment. 4 Clobal totals for mathractice RVUs may not sum due to roundine.		-	Doc advncd dis c	emfrt not 1st	0.00	0.00	000	0.00	XXX	11921	×	Correct skin color defects	1.93	3.06	1.54	0.28	000
XXX 11950 R Therapy for contour defects 0.84 1.06 0.55 0.05 1 CPT codes and descriptions only are copyright 2009 American Medical Association All Rights Reserved. 2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a coursey to the general public and are not used for Medicare payment. 3 The budget neutrality reduction from the churopractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare program. 4 Clobal totals for mathractice RVUs may not sum due to coundine.		_	Advnc care plan	ın rcrd	0.00	000	000	000	XXX	11922	×	Correct skin color defects	0.49	1.05	0.28	0.07	777
		I	Advnc care plan	tlk docd	0.00	0.00	0.00	000	XXX		×	Therapy for contour defects	0.84	1.06	0.55	0 05	000
		CPT codes i	and descriptions only a	are copyright 2009 Am	erican Medi	cal Associat	ion. All Rig	hts		-	CPT codes an	d descriptions only are copyright 2009 A	Атепсап Мес	lical Associat	ion All Rig	hts	
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		stablished as	s a courtesy to the gene	eral public and are not	used for Me	dicare paym	ent			₹.	stablished as a	courtesy to the general public and are n	not used for M	edicare paym	ent.		
ted in the ries used for		The budget	neutrality reduction fre	om the chiropractic dei	monstration	is not reflec	led in the R	'Us for CPT		-n 1	The budget ne	utrality reduction from the chiropractic	demonstration	is not reflec	ted in the RV	Us for CPT	
•		odes 98940,	, 98941, and 98942. II.	he required reduction v	vili only be i		he files used	101		5 2	odes 98940, 98 fedicare navm	8941, and 98942. The required reduction	n will only be	reflected in	ne mes used	101	
		Global total	yment. Is for malpractice R VI is	Is may not sum due to	rounding					. 4	Global totals f	or malpractice RVUs may not sum due	to rounding				

CPT ^{1,3} f		į	e de la companya de l	Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	i e	CPT ^{1,3} /	50 P	Descrive	Physician cian cian Work	Facility Facility Facility RVIIs ²³	Facility PE RVIIs ^{2,3}	Mal- Practice RVUs ^{2,3,4}	Global
11051	n DOM	Status	Therapy for contour defects	10	84.	0.75	0.18	000			Intmd wnd r	-	•	2.38	0.26	010
11952		. ×	Therapy for contour defects	1 69	1.45	0.67	0.10	000	12054	A	Intmd wnd repair, face/mm			2 33	0.32	010
11954		×	Therapy for contour defects	1.85	2.22	1.15	0.28	000	12055	¥	Intmd wnd repair face/mm			2.58	0.44	010
11960		Ą	Insert tissue expander(s)	11.01	NA	11.64	1.31	060	12056	V	Intmd wnd repair face/mm			2 08	0.79	010
11970		٧	Replace tissue expander	7 86	NA	7.48	1.17	060	12057	A	Intmd wnd repair face/mm	c/mm 5.97	8.02	3.41	0.53	010
11971		Ą	Remove tissue expander(s)	3.21	8.23	4.62	0.47	060	13100	A	Repair of wound or lesion			2.79	0.27	010
11975		z	Insert contraceptive cap	1.48	1.83	0.54	80.0	XXX	13101	V	Repair of wound or lesion			3.31	0.30	010
11976		ĸ	Removal of contraceptive cap	1 78	1.81	89.0	0.12	000	13102	V	Repair wound/lesion add-on			89.0	0 14	ZZZ
11977		z	Removal/remsert contra cap	3.30	2.52	1.20	0.18	XXX	13120	¥	Repair of wound or lesion			2.90	0.27	010
11980		Ą	Implant hormone pellet(s)	1 48	1.17	0.62	0.10	000	13121	V	Repair of wound or lesion			3.95	0.31	010
11981		Ą	Insert drug umplant device	1 48	1.80	0.58	0.18	XXX	13122	A	Repair wound/lesion add-on			0.76	0.15	ZZZ
11982		٧	Remove drug implant device	1 78	1.82	0.67	0.18	XXX	13131	A	Repair of wound or lesion			3.20	0.28	010
11983		٧	Remove/insert drug implant	3.30	2.14	1.12	0.26	XXX	13132	A	Repair of wound or lesion			5 44	0.43	010
12001		٧	Repair superficial wound(s)	1.72	2.18	0.97	0.16	010	13133	A	Repair wound/lesion add-on			1.24	0.19	ZZZ
12002		Ą	Repair superficial wound(s)	1.88	2.25	1.09	0.18	010	13150	V	Repair of wound or lesion			3.16	0.33	010
12004		٠	Renair superficial wound(s)	2 26	2.58	1.20	0.22	010	13151	V	Repair of wound or lesion			3.63	0.33	010
12005		: <	Repair superficial wound(s)	2 88	3.12	1.37	0.29	010	13152	A	Repair of wound or lesion			4.53	0.45	010
12006		<	Repair superficial wound(s)	3.68	3.71	1.66	0.38	010	13153	A	Repair wound/lesion add-on	uc		1.31	0.23	ZZZ
12007		₩ 4	Repair superficial wound(s)	4 13	4.07	1.85	0.45	010	13160	A	Late closure of wound			8.34	1.64	060
12011			Repair superficial wound(s)	1.78	2.34	0.97	0.17	010	14000	A	Skin tissue rearrangement			6 40	0.82	060
12013		4	Repair superficial wound(s)	2.01	2.53	1.12	0.19	010	14001	A	Skin tissue rearrangement			7.93	1.13	060
12014		< <	Repair superficial wound(s)	2.48	2.81	1.23	0.24	010	14020	A	Skin tissue rearrangement			727	0 88	060
12015		٧	Repair superficial wound(s)	3.21	3.39	1.41	0.31	010	14021	V	Skin tissue rearrangement			8.73	1.15	060
12016		٧	Repair superficial wound(s)	3 94	3 89	1.62	0.38	010	14040	A	Skin tissue rearrangement			7.76	0.97	060
12017		٧	Repair superficial wound(s)	4 72	NA	1.53	0.49	010	14041	∀	Skin tissue rearrangement			9.29	1.20	060
12018		Ą	Repair superficial wound(s)	5 54	NA	1.66	0.34	010	14060	¥	Skin tissue rearrangement			8.13	1.02	060
12020		Ą	Closure of split wound	2 64	4.21	5.09	0.27	010	14061	V	Skin tissue rearrangement			10.00	1.27	060
12021		Ą	Closure of split wound	1.86	2.13	1.56	0.21	010	14300	V	Skin tissue rearrangement			10.91	1.69	060
12031		V	Intmd wnd repair s/tr/ext	2.17	4.02	2.00	0 19	010	14350	A	Skin tissue rearrangement			7.74	1.13	060
12032		٧	Intmd wnd repair s/tr/ext	2.49	5.10	2.45	0.19	010	15002	Ą	Wound prep, trk/arm/leg			2.16	0.47	000
12034		٧	Intmd wnd repair s/tr/ext	2 94	4.80	2.26	0.29	010	15003	Ą	Wound prep, addl 100 cm) cm 0.80	1 07	0.37	0.12	ZZZ
12035		Ą	Intmd wnd repair s/tr/ext	3.44	5.93	2.52	0.41	010	15004	A	Wound prep, f/n/hf/g			2 50	0.45	000
12036		٧	Intmd wnd repair s/tr/ext	4.06	91.9	2.70	0.55	010	15005	A	Wnd prep, f/n/hf/g, addl cm	Idl cm 1.60		0.74	0.23	ZZZ
12037		Ą	Intmd wnd repair s/tr/ext	4.68	92.9	3.18	0.64	010	15040	A	Harvest cultured skm graft			1 33	0.24	000
12041		٧	Intrnd wnd repair n-hf/genit	2 39	4 09	2.04	0.20	010	15050	V.	Skm pinch graft			5.81	99.0	060
12042		V	Intrnd wnd repair n-hg/genit	2.76	4.50	2.35	0.20	010	15100	∀ '	Skm splt grft, trnk/arm/leg			8.19	1.46	060
12044		Ą	Intmd wnd repair n-hg/genit	3.16	5.73	2.25	030	010	15101	A	Skin splt grft t/a/l, add-on	d-on 1.72		1.08	0.26	777
12045		¥	Intmd wnd repair n-hg/genit	3 65	5.73	2.51	0.40	010	15110	¥	Epidrm autogrft trnk/arm/leg		_	7.86	1.63	060
12046		Ą	Intmd wnd repair n-hg/genit	4.26	8.14	3.53	0.64	010	15111	A	Epidrm autogrft t/a/l add-on	_		0.79	0.29	777
12047		¥	Intrnd wnd repair n-hg/genit	4.66	8.41	4.04	0.70	010	15115	∀ ·	Epidrm a-grft face/nck/hf/g	***	_	7 89	1.32	060
12051		٧	Intmd wnd repair face/mm	2.49	4.23	2.16	0.21	010	91161	A	Epidrm a-grit t/n/ht/g addi			84.1	/5.0	777
12052		¥	Intmd wnd repair face/mm	2.81	4.84	2.75	0.21	010	15120	¥	Skn splt a-grft fac/nck/hf/g	c/hf/g 10.96	6 13.00	86.8	1.42	060
	1 CPT code	des and	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	ıcal Associa	tion. All Ri	ghts		٥ ₁	PT codes an	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	ругідіt 2009 Ашепсаг	Medical Asso	ciation. All F	1ghts	
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	- If values	s are res	Thy values are reflected for codes not payable by integrare, please note that these values have occur parablehed as a courtesy to the general miblic and are not used for Medicare payment	are, piease no	dicare navn	values have	naao		11 45	values are r	it values are retrected for course not payable by intendate, piease note mar mese value established as a courtesy to the general miblic and are not used for Medicare payment.	yable by intellerate, pied	se note utat ute or Medicare na	se values hav	- C	
	The budg	get neu	The budget neutrality reduction from the chrropractic demonstration is not re	demonstration	is not reflec	ted in the R	flected in the RVUs for CPT		IL	he budget no	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	ne chiropractic demonst	ration is not rel	flected in the	AVUs for CPT	
	codes 98940, 98941 Medicare payment	340, 989 23 23 23 23 23 23 23 23 23 23 23 23 23 2	codes 98940, 98941, and 98942. The required reduction will only be reflected	n will only be		m the files used for	d tor		00 W	codes 98940, 9894 Medicare payment	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare navment	quired reduction will on	ly be reflected	in the files us	ed for	
	Global to	otals for	Accused payment. Global totals for malpractice R VI/s may not sum due to rounding	o rounding.					, D	lobal totals	Global totals for maipractice RVUs may not sum due to rounding.	y not sum due to round	mg.			
	-		and the contract of the contra	- Comment									io I			

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

If the budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

E doing	222	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	000	000	060	060	060	060	010	ZZZ	060	060	060	060	060	060	060	060	060	000	000	000								
Mal- Practice RVIs ^{2,3,4}	000	1.53	1 35	1.20	1.02	0.28	0.35	0.45	0.48	0.56	1.77	2.15	2.98	2.52	2.86	1.29	1.70	4 72	4 33	4.15	1.10	Ξ	0.21	0.30	0.89	0.57	0.47	0.46	0 18	0 02	0.27	0.53	0.23	0 41	1.56	032	0.49	0.31	0.49	0.00	0.00	0.00	thts		peen	VIIIe for CPT	VOS 101 Ct 1 I for			
Facility PE RVIIs ^{2,3}	0.00	8.01	8.65	8.89	7.92	3.16	3.54	4.45	4.73	4.88	11.81	14.55	14.33	12.28	12 72	10.37	10.43	23.73	22.86	22.27	838	7 99	1 79	2.37	7.11	5.84	5.35	5.16	1.52	0.16	4.27	2.67	4.75	5.21	7.89	92.9	7.10	5.31	8.29	0.00	0.00	0.00	tion. All Rig		values have	nent.	the files used			
Non- Facility PE RVIIs ^{2,3}	0.00	12.12	11.85	12.29	11.04	5.92	6.23	7.09	7 38	7.70	14.54	18.32	18.52	16.40	16.58	14.05	Z	Ą	Ą	Z	11.73	Ϋ́	3 57	4.89	11.86	8.60	9.13	7.73	4.17	0.92	9.46	8.73	0.00	8.15	NA	8.03	8.55	6.57	9.70	0.00	0.00	0.00	lical Associa		te that these	edicare payn	reflected in			
Physi- cian Work	0.00	10.00	9.94	10 52	9.24	1.95	2.46	3.62	3.95	4.64	14.12	19.70	19.62	16.92	18.92	11.57	12.73	36.74	36.05	36.70	896	8.73	3.05	5.53	8.50	4.91	4.36	4.33	2.05	0.33	2.09	4.91	1.86	3.82	10.45	60.9	99.9	4.51	8.12	0.00	0.00	0.00	merican Me		are, please no	ot used tor M	nemonsuarro n will only be		to rounding.	1
Description	Apply acellular xgraft add	Form skin pedicle flap	Form skm pedicle flap	Form skin pedicle flap	Form skin pedicle flap	Skin graft	Skm graft	Skm graft	Skin graft	Transfer skin pedicle flap	Forehead flap w/vasc pedicle	Muscle-skin graft, head/neck	Muscle-skm graft, trunk	Muscle-skin graft, arm	Muscle-skin graft, leg	Island nedicle flan oraft	Neurovascular nedicle graft	Free myo/skin flan microvasc	Free skin flan microvasc	Free fascial flan microvasc	Composite skin oraft	Derma-fat-fascia graft	Hair transplant minch orafts	Hair transplant nunch grafts	Abrasion treatment of skin	Abrasion treatment of skin	Abrasion treatment of skin	Abrasion treatment of skin	Abrasion, lesion, single	Abrasion, lesions, add-on	Chemical peel, face, epiderm	Chemical peel, face, dermal	Chemical peel, nonfacial	Chemical peel, nonfacial	Plastic surgery, neck	Revision of lower eyelid	Revision of lower eyelid	Revision of upper eyelid	Revision of upper eyelid	Removal of forehead wrinkles	Removal of neck wrinkles	Removal of brow wrinkles	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The hindrer neutrality reduction from the chrowesofte demonstration is not reflected in the DVI is for OPT.	I ne dudget neutranty reduction from the chiropractic demonstration is not reflected in the KVOS codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	ot,	Global totals for malpractice RVUs may not sum due to rounding	
e i te	ပ	V	V	V	Ą	A	٧	V	٧	A	٧	A	٧	Ą	Ą	. ⋖	. ⊲	; ∢	. 4	: ∢	. ⊲	: ∢	; œ	· ~	4	V	A	A	¥	V	~	~	~	٧	Ą	٧	V	V	A	~	~	~	codes and	,eq.	lues are ref	shed as a c	98940, 989	Medicare payment	al totals for	
leited		15570	15572	15574	15576	15600	15610	15620	15630	15650	15731	15732	15734	15736	15738	15740	15750	35751	15757	15758	15760	15770	15775	15776	15780	18781	15782	15783	15786	15787	15788	15789	15792	15793	15819	15820	15821	15822	15823	15824	15825	15826	1 CPT	Reserved.	· If va	establi 3 The	codes	Medic	⁴ Glob	
in the second	ZZZ	060	ZZZ	060	ZZZ	060	ZZZ	ZZZ	060	ZZZ	ZZZ	060	ZZZ	060	ZZZ	060	777	000	777	060	777	060	777	060	ZZZ	060	777	060	ZZZ	060	ZZZ	010	ZZZ	060	ZZZ	060	ZZZ	060	ZZZ	060	ZZZ	060				Ę	-			
Mal- Practice DVII-63.4 Global				1.28 090				0.37 ZZZ								121 090								0.64 090		0.54 090																0.71 090	ghts		been	VII's for OPT	d for			
	0.38	1.10	0.24	1.28		151	0 32	0.37		0.41	0.16	0.82	0.24		0.30		010	01.0	0.16		0.23	1 24	0.23		0.15		0.23	0.59	0.15	0.36	80.0		0.05	0.42	0.15	0.29	0.11	0.51	0.15		0.22		tion. All Rights		values have been	lent. ted in the DVII's for CDT	the files used for			
Mal- Practice	1.67 0.38	6.61 1.10	0.56 0.24	8.41 1.28	0.00 09 0	6.29 1 51	0.74 0.32	0.93 0.37	4.62 0.55	0.41	1.09 0.16	3.53 0.82	0.66 0.24	3.80 0.77	1.01 0.30	787 121	064 019	01.0	20:1	1.25	1.05 0.23	10.48 1.24	1.45 0.22	0.64	0.46 0.15	2.71 0.54	0.68 0.23	2.75 0.59	0.47 0.15	2.25 0.36	0.35 0.08	3.05 0.35	0.17 0.05	0.42	0.45 0.15	3.25 0.29	0 43 0.11	4.64 0.51	0.15	4.92 0.49	0.22	0.71	ical Association. All Rights		e that these values have been	sdicare payment.	is not restroyed in the reversion or 1			
Facility Mal- PE Practice Political Puractice	3.98 1.67 0.38	9.20 6.61 1.10	0.76 0.56 0.24	10.94 8.41 1.28	0.73 0 60 0.09	6.29 1 51	0.97 0.74 0.32	1 17 0.93 0.37	5 79 4.62 0.55	1.43 1.23 0.41	1.35 1.09 0.16	5.12 3.53 0.82	0.81 0.66 0.24	5.27 3.80 0.77	1.28 1.01 0.30	11 57 787 121	236 064 019	762 102	7.32 7.32	13.08 10.07 1.25	2.81 1.05 0.23	13.85 10.48 1.24	3.73 1.45 0.22	4.29 2.81 0.64	0.61 0.46 0.15	430 2.71 0.54	0.87 0.68 0.23	2.75 0.59	0.61 0.47 0.15	2.25 0.36	0.55 0.35 0.08	3.05 0.35	0.73 0.17 0.05	5.08 3.71 0.42	0.65 0.45 0.15	3.25 0.29	0 63 0 43 0.11	6.01 4.64 0.51	1.16 0.42 0.15	4.92 0.49	0.67 0.22	0.71			e, please note that these values have been	t used for Medicare payment.	choust attou is not reflected in the reversity of the version of a will only be reflected in the files used for		rounding.	,
Non- Facility Facility Mal- PE PE Practice Per Per Practice /	A Skn splta-grift fin hilling add 2.67 3.98 1.67 0.38	Derm autograft, trnk/arm/leg 7.41 9.20 6.61 1.10	Derm autograft t/a/l add-on 1.50 0.76 0.56 0.24	g 10.91 10.94 8.41 1.28	0.73 0 60 0.09	7.74 6.29 1.51	Cult epiderm grft t/a/l addi 2.00 0.97 0.74 0.32	Cult epiderm graft t/a/1 +% 2.50 1 17 0.93 0.37	Cult epiderm graft, f/u/hf/g 10.05 5 79 4.62 0.55	Cult epidrm grft f/n/hfg add 2.75 1.43 1.23 0.41	3 00 1.35 1.09 0.16	Acell graft trunk/arms/legs 5 99 5.12 3.53 0.82	Acell graft t/arm/leg add-on 1.55 0.81 0.66 0.24	Acellular graft, flu/ht/g 7.99 5.27 3.80 0.77	Acell oraft. fin/hf/p add-on 2.45 1.28 1.01 0.30	Skin full graft trunk 8 97 11 57 787 121	Skin full crash trunk add-on 1 32 2 36 0 64 0 10	Skin fall maß soln/arm/lag 7.05 11.35 7.62 1.03	20:1 20:1 20:1 01:1	Skin full ord face/oent/Af 1015 13.08 10.07 1.25	186 281 1.05 0.23	Skin fail oraft een & line 1139 1385 10.48 1.24	Skin fall araft add-on 22 32 145 022	Amily skinalloorfit t/arm/lo 4.65 4.29 2.81 0.64	1.00 0.61 0.46 0.15	Apply skin allogrif fin/hf/g 5.36 4.30 2.71 0.54	Apiv sknallogrif fin/hig add 1.50 0.87 0.68 0.23	Aply acell alogn the varm/leg 3.99 4.26 2.75 0.59	Aply acell grft t/a/l add-on 100 0.61 0.47 0.15	4.50 3.66 2.25 0.36	Aply acell grff f/n/hf/g add 1.43 0.55 0.35 0.08	4.24 3.05 0.35	1 0.50 0.73 0.17 0.05	3.93 5.08 3.71 0.42	0.65 0.45 0.15	4.46 3.25 0.29	0 63 0 43 0.11	438 6.01 4.64 0.51	1.16 0.42 0.15	6.22 4.92 0.49	1.42 0.67 0.22	5.93 7.59 6.97 0.71	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved.	'If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courfest, to the general public and are not used for Medicare payment. 3.11. In the state of the second to the	The budget neutrality reduction from the chroptractic demonstration is not reflected in the KVUS for C.F.1 codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	ocasion of the control of the contro	⁴ Global totals for malpractice RVUs may not sum due to rounding.	

	Global 090	λλλ λ	000	000	000	00	000	777	010	010	060	060	060	010	010	000	010	010	010	010	010	010	010	010	010	010	010	010	010	010	010	010	000	ZZZ	000	ZZZ	ZZZ	010	010	
Mal- Practice	RVUs ^{2,3,4}	00.0	0.07	0.07	0.19	0.25	0.46	0.19	40.0	0.00	0.38	0.52	0.81	0.04	0.05	0.05	0.05	0.07	0.00	0.10	0.11	0.15	80.0	0.09	0.12	0.15	0.21	0.07	0.10	0.12	010	0.32	0.35	0.19	0.32	0.17	0.05	0.05	80:0	ghts
Facility PE	RVUs ^{2, 3}	000	0.33	0.71	1.17	1.34	136	0.04	//:0	1.51	3 27	3 98	5.05	1.06	1.21	0 43	0.78	1.12	1.37	1.50	1.57	1.79	1.19	1 40	1 65	1 95	2.28	0 :	.45	40.1	231	2.97	3.75	1 99	3.36	1.85	0.53	0.48	1:1	tion. All Ri
Non- Facility PE	RVUs ^{2,3}	000	0.91	1.35	2.00	2.52	NA.	V ?	1.36	2 43	4.22	5.44	7.16	2.03	2.29	1.45	1.39	2.33	5.69	2.93	3.13	3.43	2.36	2.34	3.10	3.53	3.94	2.26	2.65	8. 6 4. 2	3 07	4.72	10.16	6.40	9.34	5.93	1.13	0.54	1.82	lical Associa
Physi- cian Work	RVUs ^{2,3}	000	0.89	0.80	1.85	2.08	3.74	1.50	0.62	1.83	3.61	4.68	6.37	0.67	0.94	0.50	0.93	1.19	1.60	1.81	1.96	2.36	1.34	1 20	2.07	2.61	3.22	1.19	1.74	2.06	2,73	4.45	6.20	3.30	5.56	3.06	0.87	92 0	1.44	Атепсан Мес
	Description Persons thirth presents sores	Removal of pressure sore	Initial treatment of burn(s)	Dress/debrid p-thick burn, s	Dress/debrid p-thick burn, m	Dress/debrid p-thick burn, 1	Incision of burn scab, miti	Escharotomy; addÆl incision	Destruct premalg lesion	Destroy premia lessone 15+	Destruction of skm lesions	Destruction of skin lesions	Destruction of skin lesions	Destruct b9 lesion, 1-14	Destruct lesion, 15 or more	Chemical cautery, tissue	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of skin lesions	Destruction of sleep logical	Destriction of skin lesions	Mohs, 1 stage, h/n/hf/g	Mohs addl stage	Mohs, 1 stage, t/a/1	Mohs, addl stage, t/a/l	Mohs surg, addl block	Cryotherapy of skm	Skin peel therapy	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights
	Status ^Δ	د ر	Α (¥	Ą	¥	V	∢ .	۷٠	< <	: ∢	٧	Ą	Ą	¥	Ą	Ą	V	٧	Ą	¥	V	∢ .	< <	< ∢	Ą	V	A	۷ .	< <	(<	< ∢	: <	<	V	A	Ą	¥	V	odes and
	Wod																																							CPT coc
CPT13/	HCPCS 15058	15000	16000	16020	16025	16030	16035	16036	17000	17004	17106	17107	17108	17110	17111	17250	17260	17261	17262	17263	17264	17266	17270	17271	17273	17274	17276	17280	17281	17282	17364	17286	17311	17312	17313	17314	17315	17340	17360	
	12.3.4 Global																																				060 4	060 0	4 090	
Mal- Practice	RVUs ^{2:}	2.0	2.48	1.8	1.7	1.7	2.0	1.5	1.5	<u> </u>	1.6	2.5	3.9	0.8	0.0	00	00	0.0	0.2	0.0	0.0	0.0	0.0	7 1	15	18	2.0	2.3	2.0	2.2		0. 7	2.0	3.6	12	1.7	1.9	2.0	2.5	Rights
Facility PE	RVUs ² :	8.0	12.60	9.94	10.42	10.59	8.25	7 30	2 5	3 6	4	~	6	0							0	2	0		- 2	4		17	~	ο.	3 5	- 4	000	4	6.42	8.41	8.19	11.92	12.10	ition. All
Non- Facility PE	/Us ² 3										3 <u>-</u>	16.1	28.5	11.90	0.00	0.28	0.34	0.33	1.16	0.00	0.0	0	0.0	0.8	6.9	9.4	69.6	12.	9.3	11.11	? 5	10.01	1.2	17.						22
	Œ.	9 6	NA N	NA	NA	NA	NA	NA.																											NA VA	NA	NA	NA	NA	dical Associa
Physi- cian Work									10.30		Y AN	N Y		NA	0.00	1.38	1 56	NA	NA	0.00	0.00	0.00	000		Y X	NA	NA	NA	NA		V V	K N	Y X	Ä	7.91 NA	11.41 NA	12.14 NA	13.39 NA	16.59 NA	American Medical Associa
Physi- cian Work	Description RVUs ^{2,3}	Demond of the winners 0.00	Exc skin abd 16.90	Excise excessive skin tissue 12.65	Excise excessive skm tissue 11.70	Excise excessive skin tissue 11.97	Excise excessive skin tissue 12 79	Excise excessive skin tissue 10.41	Excise excessive skin tissue 9.37 10.30	Excise excessive skin usue 8.0/ I/A	Graft for face nerve palsy 14.76 NA	Graft for face nerve palsy 25 69 NA	Flap for face nerve palsy 40.68 NA	Skin and muscle repair, face 14.04 NA	Exc skm abd add-on 0.00 0.00	Removal of sutures 0.78 1.38	Removal of sutures 0.86 1 56	Dressing change not for burn 0.86 NA	Test for blood flow in graft 1.95 NA	Suction assisted lipectomy 0.00 0.00	Removal of tail bone ulcer 8.15 NA	Remove sacrum pressure sore 9.96 NA	Remove sacrum pressure sore 11.60 NA	Remove sacrum pressure sore 13.54 NA	Remove sacrum pressure sore 15.58 NA	Remove sacrum pressure sore 13.04 NA	Remove sacrum pressure sore 15.00 NA	Remove hip pressure sore 10.11	Remove hip pressure sore 12.24 INA Remove hip pressure core 12.24 NA	Remove hip pressure sore 13.57 NA	23.80 NA	, p	Remove thigh pressure sore 16.59 NA	und descriptions only are copyright 2009 American Medical Associa						
Physi- cian Work	Description RVUs ^{2,3}	Demond of the winners 0.00	16.90	Excise excessive skin tissue 12.65	Excise excessive skm tissue 11.70	11.97	Excise excessive skin tissue 12 79	Excise excessive skin tissue 10.41	9.37 10.30	Excise excessive skin usue 8.0/ I/A	10:32 14:76 NA	Graft for face nerve palsy 25 69 NA	Flap for face nerve palsy 40.68 NA	14.04 NA	Exc skm abd add-on 0.00 0.00	Removal of sutures 0.78 1.38	Removal of sutures 0.86 1 56	Dressing change not for burn 0.86 NA	Test for blood flow in graft 1.95 NA	Suction assisted lipectomy 0.00 0.00	0.00 0.00	Suction assisted lipectomy 0.00 0.00	Suction assisted lipectomy 0.00 0.00	Removal of tail bone ulcer 8.15 NA	NA 9.96	Remove sacrum pressure sore 11.60 NA	Remove sacrum pressure sore 13.54 NA	Remove sacrum pressure sore 15.58 NA	Remove sacrum pressure sore 13.04 NA	Remove sacrum pressure sore 15.00 NA	Remove hip pressure sore 10.11	12.24 NA	Remove hip pressure sore 13.57 NA	23.80 NA	, p		Remove thigh pressure sore	Remove thigh pressure sore	A Remove thigh pressure sore 16.59 NA	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights

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If whether are reflected for codes not payable by Medicare, please note that these values have been restablished as a courtest to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

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The first like are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general pubble and are not used for Medicare payment.

The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 98940, 18941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Globa	060	060	060	060	060	060	060	060	060	060	060	000	YYY	010	010	010	010	010	010	060	000	000	000	000	000	010	010	010	010	010	000	XX	010	010	000	000	000	000	000	000	000	000	
Mal- Practice RVIIs ^{2,3,4}	1 36	3.04	3.46	6119	3.38	3.94	5 03	4 64	1 33	1.54	1.52	0.35	0.00	0.17	0.41	1.37	0.52	0.59	0.71	2 19	0 24	0.37	80.0	60:0	0.18	0.33	1.17	0 91	1 02	60 0	90 0	0.00	0.19	0.47	0.10	90:0	90.0	0 0 2	0.04	0 48	0.05	900	ghts
Facility PE RVIIs ^{2,3}	5.57	18 82	20.51	28 54	13.02	19.10	23.17	21.63	8.30	9.39	9.27	1.13	0.00	1.69	2 36	4.78	1.70	2.37	3.48	8.33	98.0	1.43	0.53	0 62	960	2.33	8.78	4.12	4.49	0.90	0.23	0.00	1.78	2.71	0.52	0.33	0.38	0.33	0.37	2.57	0.35	0.38	tton. All Rı
Non- Facility PE RVIIs ^{2,3}	8.75	ΝA	NA	NA	NA	NA	NA	NA	ΝA	NA	NA	4.72	0.00	3.03	4.18	NA	6.58	8.03	9 14	NA	3.49	4.57	3.61	2.50	8.33	NA	NA	NA	V	1.36	2.16	0.00	3.11	8.29	0.95	0 72	0.79	0.72	0.85	NA	0.73	0.83	ical Associa
Physician Cian Work	8.37	20.57	23.17	42.40	21.70	26.59	33.61	31.02	8.99	10.42	10.21	2.17	0.00	2.14	3.55	10.33	3.22	3.95	5.31	14.60	1.46	2.35	0.99	1.27	1.87	3.25	8.77	5.16	5.69	1.25	0.76	0.00	1.87	3.51	0.94	0.75	0.75	99.0	0.75	9009	99.0	89.0	Атепсап Ме
Daerzintion	Correct inverted nipple(s)	Breast reconstruction	Breast reconstr w/lat flap	Breast reconstruction	Breast reconstruction	Breast reconstruction	Breast reconstruction	Breast reconstruction	Surgery of breast capsule	Removal of breast capsule	Revise breast reconstruction	Design custom breast implant	Breast surgery procedure	Incision of abscess	Incision of deep abscess	Explore wound, neck	Explore wound, chest	Explore wound, abdomen	Explore wound, extremity	Excise epiphyseal bar	Muscle biopsy	Deep muscle biopsy	Needle bropsy, muscle	Bone biopsy, trocar/needle	Bone biopsy, trocar/needle	Bone biopsy, excisional	Bone biopsy, excisional	Open bone biopsy	Open bone biopsy	Injection of sinus tract	Inject smus tract for x-ray	Wound char size etc docd	Removal of foreign body	Removal of foreign body	Ther injection, carp tunnel	In tendon sheath/ligament	Inj tendon origin/insertion	Inj trigger point, 1/2 muscl	Inject trigger points, $=/>3$	Place ndl musc/tıs for rt	Drain/mject, joint/bursa	Dram/mject, jomt/bursa	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights
i ta	A	Ą	Α	Α	A	A	٧	A	¥	A	Y	A	ပ	A	A	A	Ą	A	Y	Ą	Ą	Ą	A	A	Y	V	¥	Ą	V	V	A	I	A	A	V	A	Y	٧	Ą	Y	A	A	codes and
2																																											CPT
CPT ^{1,3} /	19355	19357	19361	19364	19366	19367	19368	19369	19370	19371	19380	19396	19499	20000	20005	20100	20101	20102	20103	20150	20200	20205	20206	20220	20225	20240	20245	20250	20251	20500	20501	2050F	20520	20525	20526	20550	20551	20552	20553	20555	20600	20605	
"·	000 00																																	060 59									
/ Mal- Practice 3 DVII-2-3-4	0.00	00.00	60.0	0.04	0.58	0.11	0.19	0.49	0.17	0.36	0.28	0.70	09:0	0.94	1.06	0.47	2.95	3.79	4.45	0.10	0.05	0.00	0.57	0.27	0.58	0.83	1.60	2.23	2.52	1.24	2.77	2.86	2.89	1.65	2.38	1.08	1.26	0.95	1.25	0.94	1.83	1.33	ll Rights
Facility Mal-	0.00 0.00	0.00	0.28 0.09	0.14 0.04	3.68 0.58	0.46 0.11	0.47 0.19	2.24 0.49	0.62 0.17	1.19 0.36	1.31 0.28	4.03 0.70	3 90 0.60	4 2 7 0.94	4.64 1.06	1.09 0.47	12.21 2.95	18 49 3.79	1936 4.45	0.39 0.10	0.19 0.05	NA 0.00	1.62 0.57	0.64 0.27	2.42 0.58	4 78 0.83	6.02 1.60	8.10 2.23	9.20 2.52	6.17 1.24	10.55 2.77	11.51 2.86	11.38 2.89	8.49 1.65	12.34 2.38	5.28 1.08	7.81 1.26	6.08 0.95	7.52 1.25	3.70 0.94	1.83		ciation. All Rights
/ Mal- Practice 3 DVII-2-3-4	0.00 0.00	0.00	0.28 0.09	0.14 0.04	3.68 0.58	0.46 0.11	0.47 0.19	2.24 0.49	0.62 0.17	1.19 0.36	1.31 0.28	4.03 0.70	3 90 0.60	4 2 7 0.94	4.64 1.06	1.09 0.47	12.21 2.95	18 49 3.79	1936 4.45	0.39 0.10	0.19 0.05	NA 0.00	1.62 0.57	0.64 0.27	2.42 0.58	4 78 0.83	6.02 1.60	8.10 2.23	9.20 2.52	6.17 1.24	10.55 2.77	11.51 2.86	11.38 2.89	8.49 1.65	12.34 2.38	5.28 1.08	7.81 1.26	6.08 0.95	7.52 1.25	3.70 0.94	1.83	1.33	edical Association. All Rights
Facility Mal-	0.00 0.00	0.00 0.00	1 86 0.28 0.09	0.25 0.14 0.04	7.66 3.68 0.58	2.40 0.46 0.11	2.40 0.47 0.19	5.11 2.24 0.49	3.19 0.62 0.17	1.19 0.36	44.65 1.31 0.28	7.57 4.03 0.70	7.52 3 90 0.60	6.19 4.27 0.94	6.78 4.64 1.06	NA 1.09 0.47	NA 12.21 2.95	18 49 3.79	NA 1936 4.45	2.62 0.39 0.10	1.04 0.19 0.05	2.12 NA 0.00	1.62 0.57	NA 0.64 0.27	21.64 2.42 0.58	7 44 4 78 0.83	NA 6.02 1.60	NA 8.10 2.23	NA 9.20 2.52	NA 6.17 1.24	NA 10.55 2.77	NA 11.51 2.86	NA 11.38 2.89	NA 8.49 1.65	NA 12.34 2.38	NA 5.28 1.08	NA 7.81 1.26	NA 6.08 0.95	7.52 1.25	3.70 0.94	NA 10 99 1.83	11.62 8.06 1.33	American Medical Association. All Rights
Non- Facility Mal- PE PE Practice DVILE 23 DVILE 23-4 (0:00 0:00 0:00 0:00 0:00	00.0 00.0 00.0	ton 0.84 1.86 0.28 0.09	0.25 0.14 0.04	7.66 3.68 0.58	2.40 0.46 0.11	2.40 0.47 0.19	3.20 5.11 2.24 0.49	3.19 0.62 0.17	e 3 69 9.61 1.19 0.36	44.65 1.31 0.28	4.35 7.57 4.03 0.70	7.52 3 90 0.60	6.19 4.27 0.94	6.78 4.64 1.06	NA 1.09 0.47	NA 12.21 2.95	NA 18 49 3.79	NA 1936 4.45	1.27 2.62 0.39 0.10	1.04 0.19 0.05	2.12 NA 0.00	ad 3.63 94.74 1.62 0.57	NA 0.64 0.27	21.64 2.42 0.58	7 44 4 78 0.83	NA 6.02 1.60	toval 13.88 NA 8.10 2.23	le, complete 15 67 NA 9.20 2.52	7.81 NA 6.17 1.24	17.23 NA 10.55 2.77	a type 17.85 NA 11.51 2.86	NA 11.38 2.89	10.98 NA 8.49 1.65	NA 12.34 2.38	6.65 NA 5.28 1.08	NA 7.81 1.26	6.35 NA 6.08 0.95	NA 7.52 1.25	NA 3.70 0.94	12.40 NA 10.99 1.83	8.99 11.62 8.06 1.33	d descriptions only are copyright 2009 American Medical Association. All Rights
Physi. Non- dian Facility Mal- dian Facility Facility Mal- Work PE PE Practice Courts Drawnian Drawnia	R Hair removal by electrolysis 0.00 0.00 0.00 0.00	00.0 00.0 00.0	0.84 1.86 0.28 0.09	Drain breast lesion add-on 0.42 0.25 0.14 0.04	Incision of breast lesion 3.74 7.66 3.68 0.58	1.53 2.40 0.46 0.11	127 2.40 0.47 0.19	3.20 5.11 2.24 0.49	2 00 3.19 0.62 0.17	e 3 69 9.61 1.19 0.36	3.69 44.65 1.31 0.28	Napple exploration 4.35 7.57 4.03 0.70	3.72 7.52 3.90 0.60	Removal of breast lesion 5.84 6.19 4.27 0.94	Excision, breast lesion 6.59 6.78 4.64 1.06	Excision, addl breast lesion 2.93 NA 1.09 0.47	17.60 NA 12.21 2.95	Revision of chest wall 21.86 NA 18 49 3.79	. 24.82 NA 1936 4.45	1.27 2.62 0.39 0.10	Place needle wure, breast 0.63 1.04 0.19 0.05	0.00 2.12 NA 0.00	Place po breast cath for rad 3.63 94.74 1.62 0.57	1.72 NA 0.64 0.27	Place breast rad tube/caths 6.00 21.64 2.42 0.58	5.20 7.44 4.78 0.83	Partical mastectomy 10.00 NA 6.02 1.60	P-mastectomy w/ln removal 13.88 NA 8.10 2.23	le, complete 15 67 NA 9.20 2.52	7.81 NA 6.17 1.24	17.23 NA 10.55 2.77	a type 17.85 NA 11.51 2.86	17.95 NA 11.38 2.89	10.98 NA 8.49 1.65	15.91 NA 12.34 2.38	6.65 NA 5.28 1.08	8.52 NA 7.81 1.26	6.35 NA 6.08 0.95	8.39 NA 7.52 1.25	6.32 NA 3.70 0.94	12.40 NA 10.99 1.83	8.99 11.62 8.06 1.33	codes and descriptions only are copyright 2009 American Medical Association. All Rights
Physi: Non- dian Facility Mal- dian Facility Facility Mal- Mork PE PE Practice Description Duty, 20 puriled Description Duty, 20 puriled Description Description Description Description Description Description Description	R Hair removal by electrolysis 0.00 0.00 0.00 0.00 0.00	C Skm tissue procedure 0.00 0.00 0.00 0.00	A Dramage of breast lesson 0.84 186 0.28 0.09	Drain breast lesion add-on 0.42 0.25 0.14 0.04	Incision of breast lesion 3.74 7.66 3.68 0.58	1.53 2.40 0.46 0.11	127 2.40 0.47 0.19	3.20 5.11 2.24 0.49	Bx breast percut w/image 2 00 3.19 0.62 0.17	Bx breast percut w/device 3 69 9.61 1.19 0.36	Cryosurg ablate fa, each 3.69 44.65 1.31 0.28	Napple exploration 4.35 7.57 4.03 0.70	Excise breast duct fistula 3.72 7.52 3 90 0.60	Removal of breast lesion 5.84 6.19 4.27 0.94	Excision, breast lesion 6.59 6.78 4.64 1.06	Excision, addl breast lesion 2.93 NA 1.09 0.47	Removal of chest wall lesion 17.60 NA 12.21 2.95	Revision of chest wall 21.86 NA 18 49 3.79	Extensive chest wall surgery 24.82 NA 1936 4.45	Place needle wre, breast 1.27 2.62 0.39 0.10	Place needle wure, breast 0.63 1.04 0.19 0.05	Place breast clip, percut 0.00 2.12 NA 0.00	Place po breast cath for rad 3.63 94.74 1.62 0.57	Place breast cath for rad 1.72 NA 0.64 0.27	Place breast rad tube/caths 6.00 21.64 2.42 0.58	Removal of breast tissue 5.20 7.44 4.78 0.83	Partical mastectomy 10.00 NA 6.02 1.60	P-mastectomy w/ln removal 13.88 NA 8.10 2.23	Mast, simple, complete 15 67 NA 9.20 2.52	7.81 NA 6.17 1.24	17.23 NA 10.55 2.77	Mast, rad, urban type 17.85 NA 11.51 2.86	Mast, mod rad 17.95 NA 11.38 2.89	Suspension of breast 10.98 NA 8.49 1.65	15.91 NA 12.34 2.38	6.65 NA 5.28 1.08	8.52 NA 7.81 1.26	6.35 NA 6.08 0.95	8.39 NA 7.52 1.25	6.32 NA 3.70 0.94	12.40 NA 10.99 1.83	8.99 11.62 8.06 1.33	'CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights

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If where are reflected for codes not payable by Medicare, please note that these values have been stabilished as a courtesy to the general public and are not used for Medicare payment.

The budger neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 98940, 8940, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

The first also are reflected for codes not payable by Medeure, please note that these values have been established as a courtiesy to the general public and are not used for Medeure payment.

The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 89840, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

4	060	000	000	060	060	060	060	9 8	99	900	000	ZZZ	YYY	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	010	060	060	060	060	060	060	060	010	060						
Mal- Practice	6 34	100	7.07	4.7	0.03	0.40	15.2	0.10	0.43	90.0	0.57	0.37	0.00	0.30	0.79	0.44	0.39	96.0	0.21	60.0	0.11	1.62	0.17	1.17	1.59	0.47	0.54	0.54	1.86	1.73	0.30	0.83	60.0	0.38	0.92	0.67	0.75	79.0	0.57	0.53	0.61	0.27	69.0	hts		cen	Us for CPT	for	
Facility PE PVIIs ^{2,3}	26.49	27.64	16.72	77.07	27.31	14.30	20.75	0.01	0/:	0 23	2 49	1 23	0.00	8.94	5.23	7.05	6.41	7.85	5.28	3.83	3.79	12.35	5.22	9.62	12.73	12.26	9.44	13.55	12.72	10.10	10.01	5.50	3.11	8.32	21.69	14.02	15.36	13.92	14.42	13.40	15.41	5.70	15.66	tion All Rig	1	values nave o	ted in the RV	the files used	
Non- Facility PE	KAUS V	V V	Ç N	V.	V.	V Y	AN .	77.1	A !	0.72	01.77	NA	0.00	NA	NA	10.13	9.10	10.96	7.57	6.03	6.21	16.08	7.53	ΝΑ	ΝΑ	NA	NA	NA	NA	Y :	YZ	NA S	5.99	11.42	27.90	19.47	21.95	86.61	20.59	20.08	22.68	8.87	19.82	dıcal Assocıa		te mat mese	n is not reflec	reflected m	
Physi- cian Work	47 33	42.33	17.65	45.11	44.26	44.19	46.95	0.62	2.60	0.62	7.27	2.50	0.00	10.90	5.59	7.23	5.54	8.26	4.80	3.26	3.28	17.17	4.80	12.61	18.13	13.97	19.83	14.47	19.08	11.54	10.91	8.50	3.33	13.40	33.70	22.31	25.06	22.85	20.84	19.27	22.48	8.99	24.88	Атепсап Ме	-	care, piease no	demonstratio	on will only be	to rounding.
	Description Mt hone and microuses	INI DOILE grait, iniciovasc	Outer bone grant, microvasc	Bone/skin gran, microvasc	Bone/skin graft, iliac crest	Bone/skin graft, metatarsal	Bone/skin graft, great toe	Electrical bone stimulation	Electrical bone stimulation	Us bone stimulation	Ablate, bone tumor(s) perq	Cptr-asst dır ms px	Musculoskeletal surgery	Incision of jaw joint	Resection of facial tumor	Excision of bone, lower jaw	Excision of facial bone(s)	Contour of face bone lesson	Excise max/zygoma b9 tumor	Remove exostosis, mandible	Remove exostosis, maxilla	Excise max/zygoma mlg tumor	Excise mandible lesion	Removal of jaw bone lesson	Extensive jaw surgery	Remove mandible cyst complex	Excise lwr jaw cyst w/repair	Remove maxilla cyst complex	Excis uppr jaw cyst w/repair	Removal of jaw joint	Remove jaw joint cartilage	Remove coronoid process	Mnpj of tmj w/anesth	Prepare face/oral prosthesis	CPT codes and descriptions only are copyright 2009 American Medical Association All Rights		It values are reflected for codes not payable by Medicare, please note that these values have been setablished as a courtesy to the general mubils and are not used for Medicare payment.	The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dedicare payment. Global totals for malpractice RVUs may not sum due to rounding.									
į	Status ^	< <	< ≺	₹ -	∢ .	۷ .	Α.	∢ .	V	A	A	A	ပ	V	Ą	Ą	Ą	Ą	٧	Ą	Ą	A	V	V	V	٧	¥	٧	٧	V	V	∢ .	∢ .	V.	V	∢	∢ .	V.	۷.	V	٧	٧	Ą	odes and d	ė.	es are rem	idget neutr	8940, 989	Medicare payment Global totals for
3	W od																																											¹ CPT o	Reserved.	- II vaiu	The bu	6 sapoo	Medicar 4 Global
CPT ^{1,3} /	20057	15607	2000	2000	20970	7/607	20973	20974	20975	20979	20982	20985	20999	21010	21015	21025	21026	21029	21030	21031	21032	21034	21040	21044	21045	21046	21047	21048	21049	21050	21060	21070	21073	21076	21077	21079	21080	21081	21082	21083	21084	21085	21086						
,		000				000		060			010																060	000			060	060	060	060	060	XXX	7777	XXX	222	777	000	060	060				CPT		
Mal- Practice	RVUs.	0.09	0.07	0.19	0.21	0.81	1.22	0.45	0.84	2.68	0.09	0.21	0.78	1.21	2.08	0.80	0.58	0.93	0.00	2.27	7.65	9.40	2.99	3.95	4.75	4.08	2.21	0.42	0.67	0.53	0.73	0.39	0.91	0.89	0.86	0.00	0.42	0.00	0.51	0.61	0.16	4.39	6.13	ughts		e peen	VUs for (ed for	
Facility PE	RVUs.	0.49	65.0	70.	1.61	1.85	6.62	3.98	5.82	8.81	0.99	1.94	4.80	9.00	11.92	5.36	4.19	10 03	NA	19.21	30.91	42.53	19.84	17.72	19.93	18.12	21.27	2.50	3.16	5.12	5.88	4.78	5.41	5.98	5.21	0.00	0.85	0.00	1.36	1.45	1.02	23.48	25.30	tion. All R		these values have been	reflected in the RVUs for CPT	ted in the files used for	
Non- Facility PE	RVUs"	77.1	79.0	3.00	2.76	Ν	NA	Y :	NA	NA	1.33	7.58	9.47	NA	NA	NA	6.25	NA	39.58	NA	NA	NA	NA	NA	NA	NA	NA	7.32	NA	NA	NA	V.	7.90	ΝA	NA	0.00	NA.	0.00	NA	NA	4.72	NA	NA	ical Associa		e that these valu		reflected m	
Physi- cian Work	RVUs.	0.79	0.70	2.30	2.25	4 00	5.14	6 26	5.62	98.6	1 33	1 76	5.90	8.65	16.00	5.97	4.20	17.32	0.00	42.30	51.14	62.77	31.74	26.42	31.74	27.24	42.56	3.00	4.58	5.41	6.42	5.42	6.84	6.59	5.70	0.00	181	0.00	2.79	3 02	1.26	40.02	40.93	American Med	•	care, please not	demonstration	on will only be	to rounding.
			-, (•		•	•	Halo brace application		Removal of support implant			•	•		Comp multiplane ext fixation	Comp ext fixate strut change	Replantation, arm, complete		Replantation hand, complete	Replantation digit, complete	Replantation digit, complete	Replantation thumb, complete	Replantation thumb, complete	Replantation foot, complete				_			_	_					Sp bone agrft struct add-on		Fibula bone graft, microvasc		¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		" If values are reflected for codes not payable by Medicare, please note that t	established as a courtest to the general public and are not used by treated as 3. The budget neutrality reduction from the chiropractic demonstration is not	codes 98940, 98941, and 98942. The required reduction will only be reflect	Medicare payment. 4 Global totals for maltractice RVUs may not sum due to rounding.
	Mod Status	∢ •	< -	¥ ·	Y ·	A	∢ .	∢ .	V	V	A	A	A	V	A	V	A	A	A	A	A	V	Y	V	٧	V	A	A	V	A	A	¥	V	A	V	В	V	В	V	A	¥	A	A	PT codes a	Reserved.	values are	te budget 1	s 98940,	Medicare payment. Global totals for r
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Reserved.

The values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesty to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Global	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	000	060	060	060	060	060	060	060	060	060	777	9 5	010	060	060	060	060	060	060	060	060	060			ı	-		
Mal- Practice RVUs ^{2,3,4}	2 30	030	0.21	0.44	0.40	1 66	0 79	0.56	1.40	99.0	1.14	1 26	1.25	3.00	4.0	15.0	- 1	16.0	5.06	165	1 06	1.43	1.13	1.74	0.45	0.33	0.27	0 46	0.00	0.00	0.13	0.47	0.55	0.91	0.67	0.36	10.1	1 26	1.10	1.38	ıghts	heen	,	tVUs for CP od for		
Facility PE RVUs ^{2,3}	16.28	6.85	9.78	10.09	9.75	9 26	7.15	10.54	7.87	20 16	12.95	10.06	8.69	/8 (1	9.77	9.03	1007	12.54	73.56	18 73	20.48	28.31	8.66	6 83	7 43	5.35	2.61	4.64	000	0.14	191	7.72	8.49	6.77	9.63	4.06	12 07	13.04	8.18	16.71	tton All R	values have	nent.	cted in the R the files use		
Non- Facility PE RVUs ^{2,3}	NA	27 01	15 21	43.37	80 18	NA	11 00	NA	NA	NA	Ν	15.57	Y ;	AN :	14.42	14.02	Y ;	K V	V 7	C Z	N Y	NA	14.32	NA	NA	NA	NA	NA	0.00	2.40	20.02	Š	NA	NA	NA	69.9	NA	NA	Ϋ́	Ϋ́	dical Associa	ote that these	ledicare payr	n is not refle reflected in		
Physician Cian Work RVIIs ^{2,3}	15.36	11 15	7.58	11 40	11.94	11.06	7.31	15.77	14.32	24 03	13.35	12.88	12.78	24.05	12.54	18.57	18.14	17.42	32.79	30.72	20.45	26.78	10.52	11.65	6.92	4.11	1.82	4.67	0.00	0.58	1.78	4.07	5.68	8.91	6.56	3.26	92.9	8.39	11.33	14.11	Атег сап Ме	are, please no	ot used for N	demonstration n will only be	, parties	to rounding.
Description	Reconstruct upper jaw bone	Augmentation of facial bones	Reduction of facial bones	Face bone graft	Lower jaw bone graft	Rib cartilage graft	Ear cartilage graft	Reconstruction of jaw joint	Reconstruction of jaw joint	Reconstruction of jaw joint	Reconstruction of lower jaw	Reconstruction of jaw	Reconstruction of jaw	Reconstruct lower jaw bone	Reconstruction of jaw	Reconstruction of jaw	Reconstruct lower jaw bone	Reconstruction of orbit	Revise eye sockets	Revise eve sockets	Revise eve sockets	Revise eye sockets	Augmentation, cheek bone	Revision, orbitofacial bones	Revision of eyelid	Revision of eyelid	Revision of jaw muscle/bone	Revision of jaw muscle/bone	Cranio/maxillofacial surgery	Treatment of nose fracture	Treatment of nose fracture	Treatment of nose fracture	Treatment of nose fracture	Treatment of nose fracture	Treat nasal septal fracture	Treat nasal septal fracture	Treat nasoethmoid fracture	Treat nasoethmoid fracture	Treatment of nose fracture	Treatment of smus fracture	OPT codes and descriptions only are copyright 2009 American Medical Association All Rights	Reserved. * If values are reflected for codes not navable by Medicare, please note that these values have been	stablished as a courtesy to the general public and are not used for Medicare payment	³ . The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	it.	Global totals for maipractice RVUs may not sum due to rounding
S. S		A	Α	A	Ą	A	A	A	Ą	Y	A	Ą	V	V ·	¥ ·	Α.	∀ .	∢ <	Κ <	< ⊲	: ∢	. ∢	A	Ą	A	A	Ą	A	ပ	۷,	₹ 4	< ∢	. ∢	A	Α	Ą	Α	A	A	¥	codes and	ved.	lished as a c	budget neur 98940, 989	Medicare payment.	Dal totais ioi
CPT'3/ HCPCS Mod	,	21208	21209	21210	21215	21230	21235	21240	21242	21243	21244	21245	21246	21247	21248	21249	21255	21250	21700	21201	21267	21268	21270	21275	21280	21282	21295	21296	21299	21310	21313	21320	21330	21335	21336	21337	21338	21339	21340	21343	CPT	Reserved.	establ	⁵ The	Medic	כוסו
Gobal	060	060	YYY	060	060	000	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060				ı		
Mal- Practice	0.75	0.00	0.00	0.48	0.19	0.05	0.75	0.21	0.46	0.31	1.60	1.19	0.54	1.36	0.80	0.53	2.99	3.30	0.00	70.0	1 38	2.81	3.03	96.0	4.18	2.51	1.46	60.6	3.37	2.48	3.16	1 85	5.76	2.24	0.51	2.10	1.84	1.63	1.48	1.62	ghts	hoen	,	VUs for CP		
Facility PE DVII-2-3	15.21	0.00	0.00	5.03	10.81	0 38	8.14	6.72	7 93	11.87	10 01	8 92	9.11	10.42	9.28	10.00	16.27	13.04	07.11	19.09	14.78	19.84	21.25	16.69	26.82	22.80	20.24	21.91	13.50	14.95	7. IS	24.08	23.33	21 89	10.20	14.12	15 74	15.77	13.56	68.6	ation. All Ri	evelues have	nent.	cted in the R		
Non- Facility PE	19.37	0.00	0.00	13.17	13.91	3 15	11.42	9 26	NA	NA	77.93	84.54	NA	NA	NA	NA.	Y :	Y ;	N A	¥ ×	Z Z	N	NA	NA	NA	NA	NA	NA	NA	Y ;	Y Z	K Z	N A	NA	NA	NA	NA	NA	NA	NA	dical Associ	to that these	fedicare pay	n is not refle reflected in		
Physician Cian Work	24.88	0.00	0.00	4.56	5.80	0.81	4.99	7 70	8 59	11 22	10.68	12.24	10.12	12.73	14.90	19.27	19.98	20.75	40.57	24.34	25.78	28.84	31.05	34.98	42.90	46.95	28.07	33.43	22.53	25.46	37.45	35.57	38.49	22.97	18.65	21.54	18.88	20.55	15.48	16.62	merican Me	n escelu en	ot used for N	demonstratio	-	o rounding.
Description	Prepare face/oral prosthesis	Prepare face/oral prosthesis	Prepare face/oral prosthesis	Maxillofacial fixation	Interdental fixation	Injection, jaw joint x-ray	Reconstruction of chm	Reconstruction of chin	Reconstruction of chin	Reconstruction of chm	Augmentation, lower jaw bone	Augmentation, lower jaw bone	Reduction of forehead	Reduction of forehead	Reduction of forehead	Reconstruct midface, lefort	Reconstruct midface, lefort	Reconstruct midtace, lefort	Reconstruct midface, lefort	Reconstruct midiace, lefort	Reconstruct midface lefort	Reconstruct midface, lefort	Reconstruct midface, lefort	Reconstruct midface, lefort	Reconstruct midface, lefort	Reconstruct midface, lefort	Reconstruct orbit/forehead	Reconstruct orbit/forehead	Reconstruct entire forehead	Reconstruct entire forehead	Contour crantal bone lesion	Reconstruct cranial bone	Reconstruct cranial bone	Reconstruction of midface	Reconst lwr jaw w/o graft	Reconst lwr jaw w/graft	Reconst lwr jaw w/o fixation	Reconst lwr jaw w/fixation	Reconstr lwr jaw segment	Reconstr lwr Jaw w/advance	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. I feagling one reflected for codes not navable by Medicare alease note that these values have been	It values are refrected for cours not payable by wearedar, prease note that mess value established as a courtesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 08040_08041_and 08042_The required reduction will only be reflected in the files used for	ent.	Global totals for malpractice RVUs may not sum due to rounding
ä		ပ	၁	A	A	A	٧	A	A	A	Α	A	A	∢	A	A	A	Α.	۷,	∢ <	< ∢	: ∢	· •	A	A	V	A	A	V	V ·	< <	< 4	< ∢	A	A	A	A	A	V	¥	T codes and	Reserved.	values are as a blished as a	ne budget ne	Medicare payment	obal totals 1.
CPT ⁽³)		21088	21089	21100	21110	21116	21120	21121	21122	21123	21125	21127	21137	21138	21139	21141	21142	21143	21145	21140	21150	21151	21154	21155	21159	21160	21172	21175	21179	21180	21181	21182	21184	21188	21193	21194	21195	21196	21198	21199		Res 2 rf	esta	T.	We a	خ

Exeserved.

If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 89940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Physical cian cian work	Physical cian cian Work	Physi- cian Work		Non- Facility PE	Facility PE	Mal- Practice					Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	
RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} (Bescription RVUs ^{2,3} RVUs ^{2,3,4} (RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} (RVUs ^{2,3} RVUs ^{2,3,4} (3 RVUs ^{2,3,4} (•	٠	Slobal	HCPCS Mod S	Status	Description	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2, 3, 4}	Global
ture 21.30 NA 18.35 5.20	ture 21.30 NA 18.35 5.20	NA 18.55 5.20	18.55 5.20	3.20		•	060	21493	۲ <	Interded to the macture	4 45	12.30	07.0	510	000
NA 12.14 1.10	6.8/ 111 /6.8/ 0.8/ 0.11 1.0/ 1.10	NA 12.14 1.10	1.57 0.67	0.97		_	060	2149)	(ر	Head curgery procedure	7 0	000	000	0.00	<u>}</u>
12.27 NA 12.03 1.30	12.27 NA 12.03 1.30	NA 12.03 1.30	12 03 1 30	1.10		Ö	06	21501) 4	Drain neck/chest lesion	7 8 7	7.35	4 10	0.55	060
17.36 NA 11.14 1.69	17.36 NA 11.14 1.69	NA 11.14 1.69	11.14	1.69			060	21502	. 4	Dram chest lesion	7.43	NA	5 72	1.20	060
re 4.32 6.60 3.91	re 4.32 6.60 3.91	6 60 3.91	3.91		0.28		010	21510	4	Dramage of bone lesion	90 9	NA	4.79	1.08	060
4.70 7.47 4.62	4.70 7.47 4.62	7.47 4.62	4.62		0.34		010	21550	¥	Biopsy of neck/chest	2 08	4.34	1 88	0.18	010
7.03 NA 6.28	7.03 NA 6.28	NA 6.28	6.28		69.0		060	21555	٧	Remove lesion, neck/chest	4 40	6 75	4.18	99.0	060
NA 11 43	16.52 NA 11.43	NA 11 43	11 43		1.66		060	21556	Ą	Remove lesion, neck/chest	5 63	NA	5 01	080	060
NA 1438	18 44 NA 14 38	NA 1438	14 38		1.80		060	21557	Ą	Remove tumor, neck/chest	8.91	NA	5 79	1 27	060
8.29	9.46 NA 8.29	NA 8.29	8.29		0.92		060	21600	Ą	Partial removal of rib	7.14	NA	6 92	1.17	060
NA 6.85	9 46 NA 6.85	NA 6.85	6.85		1.42		060	21610	٧	Partial removal of rib	15.76	ΑN	11.91	4.28	060
NA 8.54 0.98	10.00 NA 8.54 0.98	NA 8.54 0.98	8.54 0.98	0.98		Ŭ	060	21615	Ą	Removal of rib	10.31	NA	5.90	1.86	060
Treat eye socket fracture 11.07 NA 9.14 1.02	11.07 NA 9.14 1.02	NA 9.14 1.02	9.14 1.02	1.02		0	06	21616	Ą	Removal of rib and nerves	12.54	NA	6.26	2.26	060
14.62 NA 9.25 1.43	14.62 NA 9.25 1.43	NA 9.25 1.43	9.25 1.43	1.43		8	00	21620	٧	Partial removal of sternum	7.16	NA	5.63	1.22	060
Treat eve socket fracture 1.44 3.13 2.29 0.17	1.44 3.13 2.29 0.17	3.13 2.29 0.17	2.29 0.17	0.17		0	06	21627	Ą	Sternal debridement	7.18	NA	6.42	1.24	060
Treat eve socket fracture 3.57 7.94 3.75 0.53	3.57 7.94 3.75 0.53	7.94 3.75 0.53	3.75 0.53	0.53		ŏ	06	21630	A	Extensive stemum surgery	19.01	NA	12.35	3.02	060
Treat eye socket fracture 7.31 NA 6.01 0.71	7.31 NA 6.01 0.71	NA 6.01 0.71	6.01 0.71	0.71		0	06	21632	Ą	Extensive sternum surgery	19.51	NA	11.13	3.71	060
Treat eve socket fracture 8.91 NA 7.62 0.92	8.91 NA 7.62 0.92	NA 7.62 0.92	7.62 0.92	0.92		60	0	21685	Ą	Hyord myotomy & suspension	14.89	NA	10.70	1.44	060
12.67 NA 10.46 1.90	12.67 NA 10.46 1.90	NA 10.46 1.90	10.46 1.90	1.90		8	0	21700	Ą	Revision of neck muscle	6.23	Ν	3.21	1.12	060
Treat mouth roof fracture 5.80 12.80 9.96 0.87	5.80 12.80 9.96 0.87	12.80 9.96 0.87	9.96	0.87		9	0	21705	Ą	Revision of neck muscle/rib	9.83	NA	4.26	1.77	060
NA 8.17 0.74	8.62 NA 8.17 0.74	NA 8.17 0.74	8.17 0.74	0.74		_	060	21720	Ą	Revision of neck muscle	5.72	NA	4.76	1.56	060
Treat mouth roof fracture 10.71 NA 8.87 0.96	10.71 NA 8.87 0.96	NA 8.87 0.96	8.87 0.96	96.0			060	21725	Ą	Revision of neck muscle	7.10	Ν	6.20	1.06	060
Treat craniofacial fracture 7.74 NA 12.14 1.16	7.74 NA 12.14 1.16	NA 12.14 1.16	12.14 1.16	1.16			060	21740	٧	Reconstruction of sternum	17.47	NA	8.21	3.32	060
NA 7.91 0.85	8.76 NA 7.91 0.85	NA 7.91 0.85	7.91 0.85	0.85			060	21742	ပ	Repair stern/nuss w/o scope	0.00	00.0	00.00	0.00	060
26.13 NA 15.20	26.13 NA 15.20	NA 15.20	15.20		3.91		060	21743	ပ	Repair sternum/nuss w/scope	0.00	00.00	000	0.00	060
NA 13.02	20.02 NA 13.02	NA 13.02	13.02		1.95		060	21750	Ą	Repair of sternum separation	11.35	NA	5 91	2.05	060
Treat crantofacial fracture 30 01 NA 22.61	30 01 NA 22.61	NA 22.61	22.61		1.61		060	21800	Ą	Treatment of rib fracture	86.0	1.66	1 74	0.13	060
10.24 7.85	3.28 10.24 7.85	10.24 7.85	7.85		0.09		060	21805	Ą	Treatment of rib fracture	2.80	NA	3.70	0.50	060
6.04 13.03 9.57	6.04 13.03 9.57	13.03 9.57	9.57		0.17		060	21810	٧	Treatment of rib fracture(s)	6.92	NA	5.50	1.23	060
3.55 10 56 8.07	3.55 10.56 8.07	10 56 8.07	8.07		0.10		060	21820	Ą	Treat sternum fracture	131	2.12	2.20	0.18	060
10.46 0.15	5.46 13.42 10.46 0.15	13,42 10.46 0.15	10.46 0.15	0.15			060	21825	Ą	Treat sternum fracture	7.65	NA	6:39	1.37	060
11.34 6.03 0.34	2.29 11.34 6.03 0.34	11.34 6.03 0.34	6.03 0.34	0.34		Ŭ	060	21899	ပ	Neck/chest surgery procedure	0.00	0.00	000	0.00	λλλ
6.40 14.95 12.01 0.40	6.40 14.95 12.01 0.40	14.95 12.01 0.40	12.01 0.40	0.40		Ō	06	21920	٧	Biopsy soft tissue of back	2 08	4.37	2.02	0.18	010
7 17 NA 7.31 0.20	7 17 NA 7.31 0.20	NA 7.31 0.20	7.31 0.20	0.20		50	0	21925	٧	Biopsy soft tissue of back	4.54	6.20	4.04	89.0	060
9.07 41.24 13.65 0.71	9.07 41.24 13.65 0.71	41.24 13.65 0.71	13.65 0.71	0.71		60	0	21930	Ą	Remove lesion, back or flank	5.06	7.12	4.62	0.79	060
10.77 41.30 14.02 0.69	10.77 41.30 14.02 0.69	41.30 14.02 0.69	14.02 0.69	69'0		ŏ	06	21935	٧	Remove tumor, back	18.38	ΝA	10.94	2.84	060
12.88 NA 7.23 0.35	12.88 NA 7.23 0.35	NA 7.23 0.35	7.23 0.35	0.35		Ö	06	22010	٧	I&d, p-spme, c/t/cerv-thor	12.57	NA	10.01	2.44	060
17.24 NA 12.32 1.25	1724 NA 12.32 1.25	. NA 12.32 1.25	12.32 1.25	1.25		Ī	060	22015	Ą	I&d, p-spme, I/s/ls	12.46	NA	10 04	2.28	060
0.61	0.61 1.65 0.22	1.65 0.22	0.22		0.05		000	22100	Ą	Remove part of neck vertebra	10.80	ΑN	196	2.94	060
4 58 12 66 987	788 1266 987	13 66 987	0 87		0.15		060	22101	∀ ∀	Remove nart, thorax vertehra	10.88	Ϋ́Z	10.51	2.96	060
1271 NA 714	17 1 VA 171	7 1 14	7.14		0.35		060	22102	· <	Remove part, lumbar vertebra	10.88	Ϋ́	8.99	2.04	060
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The budget neutrality reduction from the chrropractic demonstration is not reflected in the RVUs for CPT codes 89940, 8941, and 89942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding. Reserved.

The first also are reflected for codes not payable by Medicare, please note that these values have been established as a courtesty to the general pubble and are not used for Medicare payment.

The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

Facility Facility Mather Fig. 1984 PE PE PROGRAM NA 15.49 530 NA 15.49 530 NA 15.28 3.64 NA 15.22 3.98 NA 15.22 4.72 NA 15.24 1.36 NA 15.25 1.11 NA 15.22 4.72 NA 15.24 5.66 NA 24.22 10.65 NA 15.34 1.35 NA 15.34 1.36 NA 15.	
Pacifity Facility Facility Facility Facility Fig. RVU623 RVA RVU623 RVA	
PAGN-Fedelity PE RVU623 NA	
Physical Work RVUs ² 21.56 21.46 20.44 17.08 23.38 6.43 37.30 23.38 6.43 31.91 31.91 31.30 34.18 39.1	to rounding.
Mod Status Description Physit Non-reality Fresility Fresility Mathematics A Neck spand fisson 20,44 N/G 1,491 530 A Neck spand fisson 17,26 N/A 1,491 493 A Neck spand fisson 17,26 N/A 1,491 493 A Neck spand fisson 17,26 N/A 1,298 3,64 A Neck spand fisson 17,28 N/A 1,292 3,98 A Lumbar spane fisson 21,38 N/A 1,202 4,69 A Spane fisson, extra segment 2,43 N/A 1,512 4,75 A Fisson of spane 3,13 N/A 1,512 4,75 A Fisson of spane 3,13 N/A 1,54 4,69 A Fisson of spane 3,13 N/A 1,54 3,60 A Fisson of spane 3,13 N/A 1,54 3,60 A	Global totals for malpractice RVUs may not sum due to rounding.
Mod Status A A A A A A A A A A A A A A A A A A A	al totals for
CPT-31 HCPCS Mod 8 22590 22590 22595 22610 22612 22612 22614 22612 22614 22612 22614 22612 22614 22614 22614 22616 22617	⁴ Glob
Global 2222 2222 2222 2222 2222 2222 2222 2	
Mathematical Mathe	
Var. Aug.	
Non-Freiling Profiles	
Physical Modes 2	to rounding.
Mod Status Description Physit Non-reality Facility Facility Math Product A Remove catra spine segment 13.87 N.M. 1.14 0.51 A Remove part of neck vertebra 13.87 N.M. 1.081 3.77 A Remove part of neck vertebra 13.87 N.M. 1.091 2.08 A Remove part of neck vertebra 13.87 N.M. 1.091 2.05 A Remove part of neck vertebra 13.87 N.M. 1.091 2.05 A Remove part of neck vertebra 13.87 N.M. 1.091 2.05 A Cut spine 3 col, lumb 36.50 N.M. 2.103 6.84 A Cut spine 3 col, lumb 36.50 N.M. 2.103 8.84 A Cut spine 3 col, lumb 36.50 N.M. 2.13 8.91 A Cut spine 5 col, lumb 36.00 N.M. 1.13 3.74 A Cut spine 5 col, lumb 36.00 N.M. <th>$^4\mathrm{Global}$ totals for mal practice RVUs may not sum due to rounding.</th>	$^4\mathrm{Global}$ totals for mal practice RVUs may not sum due to rounding.
CPT-1-7 HGPGS 22103 22110 22110 221110 221110 222114 22207 22207 22207 22207 22216 22207 22216 22220 22221 222216 22221 22222 22222 22222 22222 22222 22222 2222	*

Global Gl

CPT ^{1,3} /		i		Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	1	CPT ⁽³⁾	3	!		Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	(
23030		A	Drain shoulder lesion	3.4	7.25	2.86	0.50	010	23397		-	Muscle transfers	16.62	S X	11.71	2.49	, -
23031		Ą	Dram shoulder bursa	2.76	7.06	2.51	0.35	010	23400	A		Fixation of shoulder blade	13.73	NA	10.31	2 06	
23035		¥	Drain shoulder bone lesion	9.04	NA	7.76	1.35	060	23405	V	Incisio	ncision of tendon & muscle	8.43	NA	7.17	1.25	_
23040		Ą	Exploratory shoulder surgery	9.63	NA	8.15	1.43	060	23406	V	_	Incise tendon(s) & muscle(s)	10.90	NA	8.39	1.59	_
23044		¥	Exploratory shoulder surgery	7.48	NA	6.70	1.12	060	23410	A		Repair rotator cuff, acute	11.23	NA	9 10	1.67	_
23065		¥	Biopsy shoulder tissues	2.28	3.15	1.96	0.22	010	23412	V	Керап	Repair rotator cuff, chronic	11.77	ΥN	9.37	1.75	_
23066		¥	Biopsy shoulder tissues	4 21	90.6	4.39	0.63	060	23415	¥	Releas	Release of shoulder ligament	10.64	NA	8.75	135	_
23075		٧	Removal of shoulder lesion	2.41	4.35	2.13	0.37	010	23420	V	Rерап	Repair of shoulder	13.35	NA	10.64	1.99	_
23076		¥	Removal of shoulder lesion	7.77	NA	6.52	1 20	060	23430	V	Repail	Repair biceps tendon	10.05	NA	8.22	1.49	_
23077		Ą	Remove tumor of shoulder	18.08	NA	12.11	2.79	060	23440	Y	Remov	Remove/transplant tendon	10.53	NA	8.25	1 55	-
23100		¥	Biopsy of shoulder joint	60.9	NA	6.14	0 91	060	23450	Y	Керап	Repair shoulder capsule	13.58	NA	96.6	2.03	_
23101		Ą	Shoulder joint surgery	5.63	NA	5.38	0.84	060	23455	V	_	Repair shoulder capsule	14.55	NA	10.43	2.16	_
23105		٧	Remove shoulder joint lining	8.36	NA	7.32	1.25	060	23460	¥	_	Repair shoulder capsule	15.68	NA	11 36	2.35	_
23106		V	Incision of collarbone joint	6.02	NA	6.11	0.00	060	23462	A		Repair shoulder capsule	15.60	NA	11 04	2.34	_
23107		V	Explore treat shoulder joint	8.75	NA	7 55	1.30	060	23465	V		Repair shoulder capsule	16.16	NA	11 54	2.42	_
23120		Ą	Partial removal, collar bone	7.23	NA	7.12	1.07	060	23466	A		Repair shoulder capsule	15.55	NA	12 25	2.31	_
23125		¥	Removal of collar bone	9.52	NA	7.95	1.42	060	23470	A		Reconstruct shoulder joint	17.75	NA	12.40	2.64	•
23130		V	Remove shoulder bone, part	7 63	NA	7.28	1.14	060	23472	A		Reconstruct shoulder joint	22.47	NA	14.91	3.32	_
23140		V	Removal of bone lesion	7.01	NA	5.84	1.03	060	23480	¥	_	Revision of collar bone	11.42	NA	8.89	171	_
23145		V	Removal of bone lesion	9.28	Y.	7.83	1.39	060	23485	V		Revision of collar bone	13.79	NA	10.05	2 03	Ĭ
23146		V	Removal of bone lesion	7.96	NA	7.28	1.19	060	23490	A	_	Remforce clavicle	12.04	NA	9.30	1 80	_
23150		A	Removal of humerus lesion	8.79	NA	7.53	1.30	060	23491	A		Remforce shoulder bones	14.40	NA	10 77	2.16	_
23155		٧	Removal of humerus lesion	10.72	NA	8.83	1.60	060	23500	A		Freat clavicle fracture	2.13	3.13	3.21	0.30	Ī
23156		¥	Removal of humerus lesion	8.99	NA	69.7	1 35	060	23505	A		Freat clavicle fracture	3.74	4.80	4.34	0.54	Ī
23170		V	Remove collar bone lesion	7.10	NA	6.64	1.06	060	23515	V		Freat clavicle fracture	9.53	NA	8.46	1.42	_
23172		Ą	Remove shoulder blade lesion	7.20	NA	699	1.08	060	23520	A		Freat clavicle dislocation	2.21	3.34	3.42	0.33	Ī
23174		Ą	Remove humerus lesion	06.6	NA	8.74	1.48	060	23525	A		freat clavicle dislocation	3 67	5.58	4 90	0.55	•
23180		V	Remove collar bone lesion	8.85	NA	7 59	1.34	060	23530	A	_	reat clavicle dislocation	7.37	NA	89.9	1.10	_
23182		A	Remove shoulder blade lesson	8.47	Υ	7.82	1.27	060	23532	V	Treat c	reat clavicle dislocation	8.08	NA	7.24	1.21	_
23184		¥	Remove humerus lesion	9.76	NA	8.40	4.	060	23540	¥	Treat c	reat clavicle dislocation	2.28	3.11	3.19	0.32	•
23190		Ą	Partial removal of scapula	7.36	NA	29.9	1.10	060	23545	V	Treat	reat clavicle dislocation	3.32	4.60	3.90	0.44	_
23195		٧	Removal of head of humerus	10.24	NA	8.40	1.53	060	23550	V	Treat c	reat clavicle dislocation	7.48	ΝΑ	09.9	1.10	_
23200		Ą	Removal of collar bone	12.69	NA	68.6	1.90	060	23552	A	Treat c	reat clavicle dislocation	8 70	NA	7 57	1.29	_
23210		V	Removal of shoulder blade	13.16	NA	10.12	1.97	060	23570	Y	Treat s	freat shoulder blade fx	2.28	3.31	3.47	0.33	_
23220		∢ .	Partial removal of humerus	15.36	NA :	11.42	2.30	060	23575	Y ·	Treats	freat shoulder blade fx	4.12	5.56	4 96	0 62	_
23221		۷.	Partial removal of humerus	18.41	V ;	76.71	2.70	060	23585	۷ ۰	Treat	reat scapula tracture	14.07	e S	10.42	/07	•
77770		< -	Fartial removal of numerus	##:C7	Z o	10.46	3.61	040	23600	< •	Treat	Treat numerus tracture	3.00	4.61	6.53	4.0	•
73330		∢ <	Nemove shoulder foreign body	7.51	0.4 V V	26.7	0.23	000	23005	< <	Treath	reat humans from	4 y 4 C	0.30	040	1.80	
73337		(<	Demove shoulder forester body	17.72	V N	20:1	1 80	060	73616	(<	Trooth	reat humanic fracture	18.12	2 2	13.61	07.0	•
23332		< ⊲	Injection for shoulder x-ray	1 00	2.56	0 33	800	000	23620	< 4	Treath	freat humerus fracture	2.46	4.03	3 73	0.36	_
23305		. ⊲	Muscle transfer shoulder/arm	18 29	Ä	13.64	2 69	060	2362	₹ 4	Treath	Treat humerus fracture	3 00	\$ 25	4 65	0.59	_
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	² If valu	ies are ref	2 If values are reflected for codes not payable by Medicare, please note that these values have been	rre, please not	e that these v	alues have b	een			2 If values are	reflected fo	If values are reflected for codes not payable by Medicare, please note that these values have been	are, please not	e that these v	alues have b	cen	
	establisi	hed as a c	established as a courtesy to the general public and are not used for N	ot used for Me	ledicare payment	ont.	TI- 6 OBT		_ 1//	established a:	a courtesy.	established as a courtesy to the general public and are not used for Medicare payment	ot used for Me	dicare paym	ent.	T40 9	
	codes 98	nager neu 8940, 989	The bugget neutrality reduction from the entropractic demonstration is not reflected in the KVUS for CFT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	remonstration	reflected in th	ed in the K v	for sor CP1		,	codes 98940.	98941. and	The budget neutrality reduction from the chiropractic demonstration is not reflected in the K v.Us for C.F.1 codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be	is not reflect reflected in t	ed in ine K he files used	for	
	Medical	Medicare payment.	nt.							Medicare payment.	ment.						
	4 Globai	1 totals for	4 Global totals for malpractice RVUs may not sum due to rounding.	o rounding.						4 Global total	s for malpra	Global totals for malpractice RVUs may not sum due to rounding.	to rounding.				

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6.91 1.50 0.90 2.4361 9.23 1.81 0.90 2.4361 9.24 0.97 0.90 2.4362 7.45 1.27 0.90 2.4365 7.45 1.27 0.90 2.4366 6.19 0.90 0.90 2.4366 6.19 0.90 0.90 2.4410 7.22 1.24 0.90 2.4420 8.15 0.90 2.4430 8.15 0.90 2.4430 8.17 0.90 2.4435 6.84 1.12 0.90 2.4435 All Rights the bottle for CPT

CPT ^{1,2} ,				Physi- clan Work	Non- Facility PE	Facility PE	Mai- Practice		(c) Ld (3)			Physi- clan Work	i Facility k PE	y Facility PE	Mat- Practice	
HCPCS	Mod	Status	Description	RVU62.3	RVUs ^{2,3}	RVUs.	RVU62 1. 4	Global	HCPCS	Mod Status		RVU	·	_	RVUs234	Global
24498		٧	Reinforce humerus	12.16	Y Y	9.31	1.82	060	24999	ပ	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	YYY
24500		¥	Treat humerus fracture	3.29	5.29	4.54	0.47	060	25000	¥	Incision of tendon sheath	3.44			0.47	060
24505		∢	Treat hunerus fracture	5.25	88.9	5.77	0.77	060	25001	V	Incise flexor carpi radialis	3.68		4.69	0.50	060
24515		<	Treat humerus fracture	11.97	ΝĀ	9.74	1.77	060	25020	¥	Decompress forearm 1 space	5.9			0.80	060
24516		4	Treat humerus fracture	12.07	NA	9.30	1.80	060	25023	V	Decompress forearm I space	13.69		14.1	2.05	060
24530		K	Treat humerus fracture	3.57	5.61	4.76	0.52	060	25024	¥	Decompress forearm 2 spaces	10.6			1.57	060
24535		4	Treat humerus fracture	96'9	8.12	7.01	1.02	060	25025	A	Decompress forearm 2 spaces	17.7		12.65	2.66	060
24538		ď	Treat humerus fracture	69.63	NA	8.60	1.43	060	25028	¥	Drainage of forearm lesion	5.3(0.76	060
24545		<	Treat humerus fracture	12.99	NA	10.07	1.91	060	25031	¥	Drainage of forearm bursa	4.18			0.63	060
24546		< <	Treat hunerus fracture	14.73	NA	11.08	2.16	060	25035	۷	Treat forearm bone lesion	7.54			1.07	060
24560		<	Treat humerus fracture	2.87	4.86	4.07	0.41	060	25040	A	Explore/treat wrist joint	7.41			1.02	060
24565		V	Treat humerus fracture	5.64	7.26	6.22	0.84	060	25065	V	Biopsy forearm soft tissues	2.01			0.17	010
24566		∢	Treat humerus fracture	8.86	NA	8.63	1.33	060	25066	¥	Biopsy forearm soft tissues	4.18	NA NA		0.59	060
24575		ĸ	Treat humerus fracture	9.53	NA	8.50	1.40	060	25075	¥	Removal forearm lesion subcu				0.56	060
24576		∢	Treat humerus fracture	2.94	5.24	4.43	0.43	060	25076	A	Removal forearm lesion deep	4.9			0.72	060
24577		٧	Treat humerus fracture	5.87	7.43	6.34	0.88	060	25077	∢	Remove tumor, forearm/wrist	96.6			1.51	060
24579		V	Treat humerus fracture	11.26	NA A	9.38	1.65	060	25085	٧	Incision of wrist capsule	5.5			0.83	060
24582		<	Treat humerus fracture	68.6	NA	9.79	1.48	060	25100	¥	Biopsy of wrist joint	3.94			0.59	060
24586		Α.	Treat elbow fracture	15.64	NA	11.37	2.27	060	25101	4	Explore/treat wrist joint	4.74			19'0	060
24587		<	Treat elbow fracture	15.65	NA	11.54	2.20	060	25105	¥	Remove wrist joint lining	16.5			0.82	060
24600		4	Treat elbow dislocation	4.28	4.53	3.85	0.57	060	25107	٧	Remove wrist joint cartilage	7.50			1.01	060
24605		∀	Treat elbow dislocation	5.50	N.A	5.88	0.81	060	25109	¥	Excise tendon forearm/wrist	6.81			0.92	060
24615		<	Treat elbow dislocation	9.72	NA	7.96	1.38	060	25110	∀	Remove wrist tendon lesion	3.90		4.37	0.57	060
24620		٧	Treat elbow fracture	7.07	NA	6:39	66'0	060	25111	∢	Remove wrist tendon lesion	3.4			0.49	060
24635		∢	Treat elbow fracture	8.64	NA	7.94	1.25	060	25112	¥	Reremove wrist tendon lesion	4.58		4.86	0.65	060
24640		<	Treat elbow dislocation	1.22	2.01	1.00	0.13	010	25115	Y	Remove wrist/forearm lesion	68.6			1,33	060
24650		Ą	Treat radius fracture	2.22	4.06	3.56	0.32	060	25116	A	Remove wrist/forearm lesion	4.83			66'0	060
24655		4	Treat radius fracture	4.48	6.15	5.23	0.64	060	25118	Y	Excise wrist tendon sheath	4.42	NA		09'0	060
24665		Ą	Treat radius fracture	8.22	ΝĄ	7.84	1.19	060	25119	A	Partial removal of ulna	91.9		6.05	0.91	060
24666		∢	Treat radius fracture	9.74	ΑN	8.44	1.39	060	25120	¥	Removal of forearm lesion	91.9			98.0	060
24670		¥	Treat ulnar fracture	2.60	4.39	3.73	0.37	060	25125	Y	Remove/graft forearm lesion	7.55		86.9	1.13	060
24675		٧	Treat ulpar fracture	4.79	6.27	5.33	0.70	060	25126	¥	Remove/graft forearm lesion	7.62			1.14	060
24685		Ą	Treat ulnar fracture	8.21	NA	7.85	1.2.1	060	25130	¥	Removal of wrist lesion	5.32			0.73	060
24800		∢	Fusion of elbow joint	11.27	NA	9.19	1.69	060	25135	A	Remove & graft wrist lesion	96.9			1.04	060
24802		٧	Fusion/graft of elbow joint	14.18	NA	10.62	2.12	060	25136	¥	Remove & graft wrist lesion	6.03	¥N •		0.90	060
24900		٧	Amputation of upper arm	10.04	NA	7.97	1.52	060	25145	¥	Remove forearm bone lesion	6.43			96:0	060
24920		¥	Amputation of upper arm	10.02	ΝΆ	8.07	1.50	060	25150	4	Partial removal of ulna	7.27			1.01	060
24925		∢	Amputation follow-up surgery	7.19	NA	89.9	1.08	060	25151	¥	Partial removal of radius	7.57			1.13	060
24930		٧	Amputation follow-up surgery	10.72	NA	8.41	1.60	060	25170	¥	Extensive forearm surgery	11.34	A NA		1.70	060
24931		A	Amputate upper arm & implant	13.32	Ϋ́	7.03	0.71	060	25210	∢	Removal of wrist bone	10.9	NA NA	6.07	0.80	060
24935		٧	Revision of amputation	16.30	NA	12.25	2.44	060	25215	¥	Removal of wrist bones	8.02	NA NA	7.32	1.05	060
24940		C	Revision of upper arm	0.00	NA	0.00	0.00	060	25230	A	Partial removal of radius	5.28	NA 1	5.40	0.67	060
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	codes 989	1940, 989	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	the files use	l for			codes 98940, 9	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	duction will on	ly be reflected	d in the files u	sed for	
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CPT ^{t-3} /				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	Š	l _{c1} LdO	į	n de la constant de l	Physical cian Work	Non- Facility PE DVIIs ²³	Facility PE RVII*	Mai- Practice RV1s ^{2,3,4}	ĕ
HCPCS	Mod	Status	Description	KVU8	KAU8	28	0.60	060		Mou State	Renair/oraft	16.31	Š Š	11.58	2.44	Ò
04767		€ <	Injection for west v-ray	1.45	2 56	0.40	0.12	000	25430	~	Vasc graft into carpal bone	9.57	NA V	8.94	06.0	Ö
25240		< ∢	Remove forearm foreign body	5.20	NA A	4.93	0.77	060	25431	A	Repair nonunion carpal bone	10.75	NA	69'8	19.1	Ò
25250		< <	Removal of wrist prosthesis	99.9	NA	6.31	1.00	060	25440	٧	Repair/graft wrist bone	10.56	NA	8.46	1.43	ō
25251		٧	Removal of wrist prosthesis	9.70	NA	8.03	1.45	060	25441	V	Reconstruct wrist joint	13.15	NA.	10.83	1.24	5
25259		¥	Manipulate wrist w/anesthes	3.86	NA	6.01	0.54	060	25442	⋖	Reconstruct wrist joint	10.98	Y ;	9.24	1.03	٥
25260		<	Repair forearm tendon/muscle	7.89	ΝA	7.64	1.09	060	25443	¥.	Reconstruct wrist joint	10.52	¥;	8.7	/5/	5
25263		K	Repair forearm tendon/muscle	7.90	ΝA	7.44	1.18	060	25444	Α.	Reconstruct wrist joint	11.28	¥;	4.0	0.00	5 6
25265		4	Repair forearm tendon/muscle	9.96	Y.	8.45	1.49	060	25445	∢ .	Reconstruct wrist joint	9/.6	e :	8.15	25.1 15.5	5 6
25270		Ą	Repair forearm tendon/muscle	90'9	Y.	6.09	0.85	060	25446	∢ •	Wrist replacement	17.16	Z ;	17.32	17.7	5 3
25272		¥	Repair forearm tendon/muscle	7.10	Y.	6.57	660	060	25447	∢ .	Repair wrist joint(s)	10.95	Y Z	10.01	0+,-	5 6
25274		¥	Repair forearm tendon/muscle	8.82	AN ;	197	1.32	060	25449	∢ ∢	Remove wnst joint implant	14.80	₹ ₹	78701	77.7	5 6
25275		∢ •	Repair forearm tendon sheath	8.82	Y Z	4.7	1.32	060	25450	< ⊲	Revision of wrist joint	1.50	< Z	288	0.51	ò
08757		∢ -	Kevise wrist/iorearm tendon	27.7	2 2		760	060	25490	; «	Reinforce radius	196	Z	7.14	0.04	Ö
06757		< ∙	Incise wrist/iorearm tendon	4.5	£ × Z	3.4.5	21.0	060	25401	(⊲	Reinforce ufna	10.03	N N	8.20	1.50	Ò
66767		< <	Kelease Wits lorearm tendon	0.01	Z Z	100	1 33	060	25492	. 4	Reinforce radius and ulna	12.52	X	18.6	1.87	٥
00567		₹ <	Fusion of tendons at wrist	0.00	4 2	757	511	060	25500	: 4	Treat fracture of radius	2.51	10.4	3,49	0.34	0
25210		(<	Transmint forearm tendon	7 94	Y Z	744	1.03	060	25505	₹	Treat fracture of radius	5.30	6.95	5.97	97.0	Ò
25212		< 4	Transplant forearm tendon	9.70	Ą	8.21	1.32	060	25515	Ą	Treat fracture of radius	8.64	NA	7.83	1.25	Ô
21315		; ∢	Revise nalsy hand tendon(s)	10.56	N	8.46	1.58	060	25520	A	Treat fracture of radius	6.35	7.42	6.72	0.95	Ö
25316		<	Revise palsy hand tendon(s)	12.76	Ν	10.62	1.20	060	25525	¥	Treat fracture of radius	10.37	NA	8.89	1.51	٥
25320		<	Repair/revise wrist joint	12.38	NA	11.93	1.66	060	25526	٧	Treat fracture of radius	12.96	NA	10.43	1.94	٥
25332		Ą	Revise wrist joint	11.60	Ν	9.29	1.64	060	25530	¥	Treat fracture of ulna	2.15	4.12	3.53	0.31	0 (
25335		ĸ	Realignment of hand	13.25	NA	7.20	0.71	060	25535	∢	Treat fracture of ulna	5.22	69.9	5.84	0.74	0
25337		٧	Reconstruct ulna/radioulnar	11.44	NA	10.51	1.50	060	25545	¥	Treat fracture of ulna	7.78	NA :	7.52	1.12	0 (
25350		¥	Revision of radius	8.97	Ϋ́	7.77	1.21	060	25560	Α.	Treat fracture radius & ulna	2.50	4.12	3.50	0.34	50
25355		¥	Revision of radius	10.41	NA NA	8.49	1.56	060	25565	∢ .	Treat fracture radius & uina	5.71	00.7	20.0	0.82	> <
25360		4	Revision of ulna	8.62	NA:	7.55	124	060	255/4	∢ •	reat fracture radius & uma	8.04	Z Z	£	77.1	5
25365		≺ .	Revise radius & ulna	12.77	¥;	48.6	1.91	060	22272	₹ <	Treat feature radius/uma	7.69	437	3.78	0.38	> C
25370		< <	Revise radius or uma	13.95	V V	7.26	0.73	060	25605	< <	Treat fracture radius/ulna	7.02	8.14	7.29	1.02	0
25300		(⊲	Shorten radius or ulna	10.58	Y Z	8 66	141	060	25606	<	Treat fx distal radial	8.10	ΝΑ	8.03	1.19	0
25301		(∢	I enother radius or ulna	14.14	N.	10.51	2.12	060	25607	¥	Treat fx rad extra-articul	9.35	NA	8.70	1.35	0
25392		: ∢	Shorten radius & ulna	14.44	NA	10.66	2.16	060	25608	¥	Treat fx rad intra-articul	10.86	NA	9.48	1.55	0
25393		¥	Lengthen radius & ulna	16.42	NA	11.63	2.46	060	25609	V	Treat fx radial 3+ frag	14.12	NA	11.77	5.00	0
25394		¥	Repair carpal bone, shorten	10.71	NA	8.60	1.60	060	25622	¥	Treat wrist bone fracture	2.68	4.65	10.4	0.38	0
25400		A	Repair radius or ulna	11.16	NA	8.90	1.56	060	25624	∀ .	Treat wrist bone fracture	4.62	6.63	5.65	0.06	5 0
25405		¥	Repair/graft radius or ulna	14.87	NA	11.05	5.06	060	25628	¥	Treat wrist bone fracture	9.51	¥.	8.32	67.1	0 0
25415		K	Repair radius & ulna	13.66	YZ :	10.71	2.04	060	25630	۷,	Treat wrist bone fracture	2.94	4.49	3.90	14.0	> 0
25420		∢	Repair/graft radius & ulna	16.89	Ϋ́ V	12.08	7.53	060	72033	€ .	reat wrist bone fracture	/ 	0.49	5.55	60.0	5 6
25425		Ą	Repair/graft radius or ulna	13.58	ΝĄ	10.23	2.03	060	25645	∢	I reat wrist bone tracture	7.31	ď.	40.0		>
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	The bi	udget ner	The budget neutrality reduction from the chiropractic demonstration	demonstration		is not reflected in the RVUs reflected in the files used for	is not reflected in the RVUs for CPT reflected in the files used for	- .	pos T	he budget les 98940.	The budget neutratity reduction from the charopractic demonstration is not reflected in the KVUS for CFT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	ctic demonstratio	on is not reflected in	oted in the K the files used	VOS TOT C.P.1	
	Medical	Medicare payment.	ent.	S (mo ma w					Me	Medicare payment	ment.					
	4 Globa	1 totals fo	Global totals for majoractice RVUs may not sum due to rounding.	to rounding.					9,	lobal total	Global totals for malpractice RVUs may not sum due to rounding	due to rounding.				

established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 9940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

No. 1995	A Treat wrist A A Amputatic A A A Amputa			•	•	0.43 0.82 1.09 0.67	060			Explore/treat hand joint	3.73	V X	3.83	0.46	
90 2007 A Explorement ligger joint 3.6 NA 416 0.49 12 900 2008 A Byopy flags joint lining 3.75 NA 5.16 0.39 12 900 2000 A Biopy flags joint lining 3.75 NA 4.44 0.56 14 900 2011 A Biopy flags joint lining 3.75 NA 4.44 0.56 14 900 2011 A Recipacy flags joint lining 3.75 NA 4.43 0.56 14 900 2011 A Recipacy flags joint lining 3.75 NA 5.29 0.82 15 900 2012 A Recipacy float lining 3.75 NA 5.95 0.82 16 900 2012 A Recipacy float lining 3.75 NA 4.43 0.56 17 900 2012 A Recipacy float lining 3.75 NA 4.43 0.56	A Pirubias A Treat fact A A Treat fact A A Treat wrish A Fusion of A Fusion of A Fusion of A Fusion of A Amputatic A A Amputatic	r styloid fracture cture ulnar styloid ist dislocation ist dislocation undrad dislocation ist dislocation ist dislocation ist dislocation ist dislocation ist fracture ist fra		~		0.82 1.09 0.67 1.12	060		٧		60,	V 14			060
90 2608 A ExploreCheat Insigner joint 1 436 NA 516 0.59 11 900 26108 A Bropsy fage joint lining 317 NA 442 0.56 14 900 26118 A Bropsy fage joint lining 317 NA 444 0.56 14 900 26118 A Bropsy fage joint lining 317 NA 444 0.56 17 900 26119 A Recover land teston, devel 561 NA 439 0.47 18 900 26119 A Recover land teston, devel 561 NA 210 110 18 900 26119 A Receive plan contention 1663 NA 258 0.82 18 900 26109 A Receive plan contention 461 NA 529 0.83 18 900 26109 A Receive plan contention 461 NA 261 0.83 18 900 26109 A Receive plan contention 461 NA	A Treat track A Treat wris A Pin radious A Treat wris A Fusion of A Fusion of A Fusion of A Fusion of A A Maputatic A A Amputatic A A A A A A A A A A A A A A A A A A A	reture ulnar styloid rist dislocation ist dislocation ulnar dislocation ist dislocation ist dislocation ist dislocation ist dislocation ist fracture rist fracture rist fracture rist fracture rist fracture rist fracture first dislocation of wrist joint graft of virist joint graft of virist joint graft of virist joint of flow-up surgery tion of forearm to of forearm tion of forearm to of forearm tion of flow-up surgery tion of f		Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	7.46 5.22 7.04 6.61 7.34 7.34 8.17 6.08 7.18	0.67		26075		Explore/treat finger joint	5.83	Z.	4.16	0.49	060
1909 26100 A Biopsy fings joint lining 317 NA 444 0.56	A Treat wris A Treat wris A Pin radious A Treat wris A Fusion of A Fusion of A Fusion of A Pusion of A Pusion of A Apputatic A Amputatic A A Drainage A Refease pa A Refeas	ist dislocation sulhar dislocation sulhar dislocation ist dislocation if wirst joint graft of wrist joint graft of wrist joint and of wrist joint ion for wrist joint ition follow-up surgery ition follow-up surgery ition of forearm the hand at wrist the hand at wrist the hand at wrist the hand at wrist to forearm to forearm it of forea		Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	5.22 6.61 6.61 7.34 7.34 5.50 6.08 7.18	1.12	060	. 26080	¥	Explore/treat finger joint	4.36	ΝΑ	5.16	0.59	060
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84 909 26123 A Release palma contracture 406 NA 246 143 35 909 26129 A Release palma contracture 406 NA 248 082 35 909 26130 A Remove wrist joint laining 548 NA 249 082 37 909 26143 A Revise fingery joint, earth 628 NA 628 083 27 909 26146 A Remove traden steath lesion 48 NA 628 084 27 909 26170 A Remove traden steath lesion 524 NA 534 0.48 27 909 26170 A Remove traden bene lesion 524 NA 534 0.64 0.48 28 909 26180 A Remove traden bene lesion 524 NA 534 0.71 29 909 2610 A Remove traden bene lesion 524 NA 53	A Treat wris A Treat wis A Fusion of A A Amputatic A A Drainage A A Drainage A A Treat hanc A A Drainage A A Treat hanc A A Release pa A A Release pa A A Recease pa A Rec	ist dislocation for disfiscation for virtis fount graft of wrist joint graft of wrist joint graft of wrist joint of hones with graft radioulnar julvina tion of forearm tion of forearm tion follow-up surgery tion of forearm te hand at wrist te hand at wrist te hand at wrist tion follow-up surgery tion of forearm to forearm to forearm the hand at wrist tion follow-up surgery tion of forearm to forearm for forearm to forearm for forearm to forearm for arm for arm for forearm forearm for forearm	5.58 8.40 9.95 11.59 11.75 7.52 9.54 9.46 9.48 7.98	X	6.08	1,49	060	26121	¥	Release palm contracture	197	A Z	7.19	1.05	060
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5.7 0.00 2.014.0 A Revise finger joint, each 6.53 NA 6.22 0.84 2.0 0.90 2.016.0 A Remove tendon excision, path/finger 6.33 NA 6.22 0.84 2.7 0.90 2.016.0 A Remove tendon stead bession 3.44 NA 5.23 0.66 2.7 0.90 2.618.0 A Remove finger tendon 5.24 NA 5.24 0.74 2.8 0.90 2.618.0 A Remove finger tendon 5.24 NA 5.54 0.71 2.9 0.90 2.620.5 A Remove finger besion 5.21 NA 5.54 0.71 2.0 0.90 2.621.5 A Remove finger besion 5.21 NA 5.54 0.71 2.0 0.90 2.621.5 A Remove finger besion 5.21 NA 5.54 0.71 2.0 0.90 2.621.5 A Remove grad bone lesion 7.16 NA <td>A Fusion grady A Fusion of A Fusion of A Fusion of A Fusion of A Amputatic Amputation Amputati</td> <td>yang of wrist joint hand boness and bones with graft radioulnar jut/ulna radioulnar jut/ulna tion of forearm tion follow-up surgery tion of forearm ten follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of forearm te hand at wrist tion follow-up surgery tion of forearm</td> <td>11.75 7.52 9.54 10.69 9.46 9.48 7.98 9.20</td> <td>& & /td> <td>9.25</td> <td>1.73</td> <td>060</td> <td>26135</td> <td>4</td> <td>Revise finger joint, each</td> <td>7.02</td> <td>Y.</td> <td>6.59</td> <td>0.95</td> <td>060</td>	A Fusion grady A Fusion of A Fusion of A Fusion of A Fusion of A Amputatic Amputation Amputati	yang of wrist joint hand boness and bones with graft radioulnar jut/ulna radioulnar jut/ulna tion of forearm tion follow-up surgery tion of forearm ten follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of forearm te hand at wrist tion follow-up surgery tion of forearm	11.75 7.52 9.54 10.69 9.46 9.48 7.98 9.20	& & & & & & & & & & & & & & & & & & &	9.25	1.73	060	26135	4	Revise finger joint, each	7.02	Y.	6.59	0.95	060
Ω 09 26145 A Tendoto accision, palluffager 6.34 NA 6.25 0.87 20 090 26170 A Remove tendon sheath besion 3.46 10.40 4.57 0.64 4.2 090 26170 A Remove tendon sheath besion 5.24 NA 5.24 0.77 1.9 090 26200 A Remove than bone tesion 5.24 NA 5.24 0.77 1.3 090 26200 A Remove than bone tesion 5.24 NA 5.54 0.77 1.3 090 26210 A Remove than bone tesion 5.24 NA 5.54 0.77 1.4 090 26210 A Remove than bone tesion 5.21 NA 5.54 0.77 1.4 090 26210 A Remove than bone tesion 5.24 NA 5.54 0.77 1.4 090 26210 A Remove than bone tesion 5.21 NA 5.54 <	A Fusion of Fusion of Fusion of A Fusion of A Fusion of A Fusion of A Amputatic A A Amputatic A A Amputatic A A Amputatic Amputation Amputatio	if hand bones ad bones with graft ad bones with graft radioulnar juvluha tion of forearm tion of forearm tion follow-up surgery tion follow-up surgery tion follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of forearm	7.52 9.54 10.69 9.46 7.98 9.20 17.38	X X X X X X X X X X X X X X X X X X X	08.6	1.57	060	26140	*	Revise finger joint, each	6.23	Y.	6.22	0.84	060
27 990 26160 A Removed tending sheath lesion 346 10.40 46.7 0.48 50 990 26170 A Removed to Johan tendon, each 48.2 NA 5.24 0.68 3.7 990 26180 A Removed figure home 5.24 NA 5.24 0.68 3.8 990 26200 A Removed figure home 5.26 NA 5.94 0.87 3.4 900 26201 A Removed figure home 5.36 NA 5.94 0.89 3.4 900 26201 A Removed figure home 5.31 NA 5.96 1.17 3.4 900 26215 A Remissive home 6.32 NA 5.93 1.04 4.0 900 26215 A Remissive home 6.33 NA 5.94 0.87 3.4 900 26225 A Partial removal of figure home 6.34 NA 5.94 0.87	A Fuse band A Pusson, ra- A Amputatic A Am	ad bones with graft radioulnar juvilina tion of forearm tion of forearm tion of forearm tion follow-up surgery tion of forearm tion follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of forearm	9.54 10.69 9.46 9.48 7.98 9.20 17.38	4 4 4 4 4 2 2 2 2 2	7.72	1.02	060	26145	∢	Tendon excision, palm/finger	6.38	ΥN	6.26	0.87	060
60 900 26170 A Removed of palm tendon, cach 482 NA 523 064 42 900 26180 A Removed lof palm tendon, cach 524 NA 529 000 42 900 26188 A Remove finger bone 632 NA 559 071 34 900 26200 A Remove finger bone 632 NA 569 071 34 900 26210 A Remove finger bone 521 NA 569 071 34 900 26220 A Remove finger bone 521 NA 569 071 34 900 26220 A Partial removal finger bone 624 NA 589 107 15 900 26220 A Partial removal finger bone 624 NA 589 107 15 900 26220 A Partial removal finger bone 624 NA 589 107 <tr< td=""><td>A Amputatic A A Drainage A Drain</td><td>radioulnar jut/ulna ition of forearm ition of forearm ition follow-up surgery ition follow-up surgery ition of forearm te hand at wrist ition follow-up surgery ition follow-up surgery ition follow-up surgery</td><td>10.69 9.46 9.48 7.98 9.20</td><td>A A A A A</td><td>9.24</td><td>1.27</td><td>060</td><td>26160</td><td><</td><td>Remove tendon sheath lesion</td><td>3.46</td><td>10.40</td><td>4.67</td><td>0.48</td><td>060</td></tr<>	A Amputatic A A Drainage A Drain	radioulnar jut/ulna ition of forearm ition of forearm ition follow-up surgery ition follow-up surgery ition of forearm te hand at wrist ition follow-up surgery ition follow-up surgery ition follow-up surgery	10.69 9.46 9.48 7.98 9.20	A A A A A	9.24	1.27	060	26160	<	Remove tendon sheath lesion	3.46	10.40	4.67	0.48	060
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42 900 26185 A Remove finger bone 652 NA 699 095 1.9 900 26205 A Remove find bone lesion 5.26 NA 6.99 0.05 1.3 900 26205 A Remove find bone lesion 7.26 NA 6.96 0.01 3.4 900 26205 A Remove find bone lesion 7.16 NA 6.96 0.01 3.4 900 26215 A Remove find finger lesion 6.38 NA 5.98 0.01 3.4 900 26225 A Partial removal of find bone 6.34 NA 5.98 0.04 3.4 900 26235 A Partial removal, finger bone 6.24 NA 6.93 1.14 1.10 900 26250 A Extensive finger surgery 7.61 NA 6.83 1.14 1.10 910 26250 A Extensive finger surgery 7.28 NA 6.83 1.14 1.20 10 26250 A Extensive finger surgery	A Amputation C Forcerror C Forcerror A Drainage A Dr	ion of forearm ion of forearm ion follow-up surgery ion follow-up surgery ion of forearm te hand at wrist the hand at wrist ion follow-up surgery ion of forearm ion follow-up surgery ion of hand	9.48 7.98 9.20 17.38	A A	8.04	1.37	060	26180	4	Removal of finger tendon	5.24	NA	5.74	89.0	060
1.9 900 26200 A Remove hand bone lesion 5.56 NA 5.54 0.77 3.3 900 26200 A Remove graft bone lesion 5.21 NA 6.96 1.17 3.4 900 26215 A Remove graft floger lesion 7.16 NA 6.96 1.17 3.4 900 26213 A Partial removal, floger bone 6.38 NA 5.97 0.71 3.4 900 26225 A Partial removal, floger bone 6.23 NA 6.63 1.07 3.4 900 26225 A Partial removal, floger bone 6.23 NA 6.93 0.72 1.15 900 26225 A Partial removal, floger bone 6.23 NA 6.93 0.72 1.10 YYY NA Partial removal, floger bone 6.24 NA 6.93 0.72 1.17 NA Partial removal, floger bone 6.24 NA 6.93 0.82 <td< td=""><td>A Amputatic A Amputatic A Amputatic A Amputatic A Amputatic A Amputatic A Amputatic C Foreaun o C Foreaun o C A Drainage o /td><td>tion follow-up surgery tion follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of hand</td><td>7.98 9.20 17.38</td><td>NA</td><td>7.81</td><td>1.42</td><td>060</td><td>26185</td><td>۷</td><td>Remove finger bone</td><td>6.32</td><td>Y Y</td><td>6.99</td><td>0.95</td><td>060</td></td<>	A Amputatic C Foreaun o C Foreaun o C A Drainage o	tion follow-up surgery tion follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of hand	7.98 9.20 17.38	NA	7.81	1.42	060	26185	۷	Remove finger bone	6.32	Y Y	6.99	0.95	060
3.8 9.09 26205 A Remove/graft bone lesion 7.82 NA 6.96 1.17 3.4 9.09 26210 A Remove/graft bone lesion 7.16 NA 6.96 1.17 3.4 9.00 26213 A Partial removal, finger bone 6.38 NA 5.98 0.84 3.0 9.00 26225 A Partial removal, finger bone 6.34 NA 5.59 0.84 1.15 9.00 26226 A Partial removal, finger bone 6.34 NA 6.59 0.84 1.15 9.00 26226 A Partial removal, finger bone 6.34 NA 6.53 0.72 1.17 9.00 26226 A Extensive band surgery 1.0 NA 6.57 1.06 1.17 9.01 26220 A Extensive finger surgery 1.28 NA 6.57 1.06 1.17 9.02 26226 A Extensive finger surgery 1.0 N	A Amputatic C Forenam C Forenam C Forenam A Drainage A Drain	tion follow-up surgery tion of forearm te hand at wrist te hand at wrist tion follow-up surgery tion of hand	9.20		7.07	1.19	060	26200	4	Remove hand bone lesion	5.56	ΝΑ	5.54	0.77	060
1.32 990 26210 A Removal of finger lesion 5.21 NA 5.67 0.71 4.40 990 26215 A Partial removal of Band bone 6.38 NA 5.67 0.71 4.40 990 26230 A Partial removal, finger bone 6.24 NA 6.63 0.83 1.5 990 26230 A Extensive band surgery 7.16 NA 6.53 0.82 1.0 990 26250 A Extensive band surgery 7.09 NA 6.83 1.14 1.0 990 26250 A Extensive band surgery 7.09 NA 6.83 1.14 1.1 900 26250 A Extensive band surgery 7.09 NA 6.83 1.14 1.1 26260 A Extensive band surgery 7.09 NA 6.83 1.14 1.2 1.1 26260 A Extensive band surgery 7.09 NA 6.83 1.14 <td>A Amputatic A Drainage A D</td> <td>tion of forearm te hand at wrist te hand at wrist te hand at wrist tion follow-up surgery tion of hand</td> <td>17.38</td> <td>NA</td> <td>1.67</td> <td>1.38</td> <td>060</td> <td>26205</td> <td>٧</td> <td>Remove/graft bone lesion</td> <td>7.82</td> <td>ΝA</td> <td>96'9</td> <td>1.17</td> <td>060</td>	A Amputatic A Drainage A D	tion of forearm te hand at wrist te hand at wrist te hand at wrist tion follow-up surgery tion of hand	17.38	NA	1.67	1.38	060	26205	٧	Remove/graft bone lesion	7.82	ΝA	96'9	1.17	060
3.4 090 20215 A Remove/graft finger lesion 7.16 NA 663 1.07 4.40 090 26230 A Partial removal of hand bone 6.24 NA 5.63 1.07 3.4 090 26235 A Partial removal, finger bone 6.24 NA 5.95 0.22 1.15 090 26250 A Extensive band surgery 7.16 NA 6.83 1.14 1.00 YYY 26260 A Extensive finger surgery 7.10 NA 6.83 1.14 1.01 VIVA 26260 A Extensive finger surgery 7.10 NA 6.87 1.06 1.02 VIVA 26260 A Extensive finger surgery 7.10 NA 6.87 1.06 1.03 0.04 26210 A Extensive finger surgery 7.10 NA 6.51 1.06 1.04 0.05 26220 A Extensive finger surgery 7.12 NA 4.53 0.53 1.05 0.06 26230 A Repair fi	A Amputate A Amputate A Amputatic A Amputatic A Amputatic C Foreum o A Drainage o A	te hand at wrist te hand at wrist tion follow-up surgery tion of hand	40	NA	19.9	2.32	060	26210	4	Removal of finger lesion	5.21	Ϋ́Α	2.67	0.71	060
(40) 690 26230 A Partial removal of hand bone 6.38 NA 5/98 0.84 3.4 690 26236 A Partial removal finger bone 6.24 NA 6.93 0.82 1.5 690 26236 A Extensive band surgery 7.61 NA 6.83 1.14 1.9 690 26250 A Extensive band surgery 7.61 NA 6.83 1.14 1.10 100 26250 A Extensive band surgery 1.280 NA 6.83 1.14 1.17 010 26261 A Extensive band surgery 1.280 NA 6.83 1.14 1.19 900 26261 A Extensive band surgery 1.29 NA 8.43 0.87 1.69 900 26320 A Extensive band surgery 1.09 NA 8.43 0.87 1.86 900 26320 A Repair finger surgery 2.62 NA 8.43 </td <td>A Amputatic A Amputatic A Amputatic A Amputatic C Forence Or Forence Or A Drainage or</td> <td>te hand at wrist tion follow-up surgery tion of hand</td> <td>8.92</td> <td>NA</td> <td>8.21</td> <td>134</td> <td>060</td> <td>26215</td> <td>٧</td> <td>Remove/graft finger lesion</td> <td>7.16</td> <td>NA</td> <td>6.63</td> <td>1.07</td> <td>060</td>	A Amputatic A Amputatic A Amputatic A Amputatic C Forence Or Forence Or A Drainage or	te hand at wrist tion follow-up surgery tion of hand	8.92	NA	8.21	134	060	26215	٧	Remove/graft finger lesion	7.16	NA	6.63	1.07	060
3.0 909 26235 A Partial removal, finger bone 6.24 NA 6.03 0.82 3.4 090 26236 A Partial removal, finger bone 6.24 NA 5.83 0.12 1.9 090 26236 A Extensive hand surgery 7.61 NA 6.83 1.14 1.0 090 26260 A Extensive hand surgery 7.61 NA 6.83 1.14 1.0 101 26261 A Extensive hand surgery 7.76 NA 6.83 1.14 1.2 010 26262 A Extensive hand surgery 7.70 NA 6.83 1.14 1.2 010 26262 A Extensive hand surgery 7.72 NA 6.83 1.14 1.0 26262 A Extensive hand surgery 7.72 NA 6.83 0.83 1.0 26222 A Repair finger waresth 5.72 NA 4.33 0.83 1.0 26220 A Repair finger waresth 2.62 NA 1.10 <td>A Amputatic A Amputatic A Amputatic C Forezaro C Forezaro A Drainage A Draina</td> <td>tion follow-up surgery tion of hand</td> <td>7.54</td> <td>NA</td> <td>5.23</td> <td>0.40</td> <td>060</td> <td>26230</td> <td>٧</td> <td>Partial removal of hand bone</td> <td>6.38</td> <td>ΝΑ</td> <td>5.98</td> <td>0.84</td> <td>060</td>	A Amputatic A Amputatic A Amputatic C Forezaro C Forezaro A Drainage A Draina	tion follow-up surgery tion of hand	7.54	NA	5.23	0.40	060	26230	٧	Partial removal of hand bone	6.38	ΝΑ	5.98	0.84	060
3.4 090 26236 A Extensive band surgery 5.37 NA 5.55 0.712 1.5 090 26255 A Extensive band surgery 7.61 NA 5.55 0.72 1.00 YYY 26256 A Extensive finger surgery 7.09 NA 6.89 1.92 1.12 010 26261 A Extensive finger surgery 7.70 NA 6.57 1.16 1.29 010 26262 A Partial remote of finger 5.72 NA 6.57 0.88 1.16 1.69 090 26320 A Removal of implant from band 4.02 NA 5.52 0.88 0.88 1.90 090 26340 A Repair finger/hand tradon 6.07 NA 1.15 0.83 1.16 1.91 090 26352 A Repair finger/hand tradon 6.07 NA 1.23 1.31 1.29 1.92 090 26352 A	A Amputation A Amputation C Forearn of A Drainage A A Decompre A A Decompre A A Release pa A	tion of hand	8.70	NA	8.47	1.30	060	26235	¥	Partial removal, finger bone	6.24	Y Z	6.03	0.82	060
15 090 26255	A Amputation C Foreaum of A Drainage of A Decompre A Decompre A Drainage of Draina		86.8	NA	10.85	1.34	060	26236	A	Partial removal, finger bone	5.37	۲.	5.55	0.72	060
19 190 1235 A Extensive band surgery 1230 NA 583 192 192 193 193 194 194 194 194 195 1	A Amputatic C Forestan A Drainage	tion follow-up surgery	1.71	NA A	6.93	1.15	060	26250	¥ ·	Extensive hand surgery	197	ζ;	6.83	4.14	2 6
1,00 YYY 20,500 A Extensive Ingers surgery 7,09 NA 0.57 1,00	C Foreignes A Drainage of A Decompre A Decompre A Decompre A Decompre A Release por A	tion follow-up surgery		NA A	10.31	1.19	060	26255	∢ ·	Extensive hand surgery	12.80	V.	9.89	76.1	260
1,1 0,10 26,261 A Extrastive Ingers (1987) 5,72 NA 54.5 0.83 1,2 0,10 26,262 A Removal of finger 5,72 NA 56.5 0.84 1,2 0,10 26,320 A Removal of finger 5,72 NA 51.5 0.53 1,2 0,00 26,320 A Removal of finger 5,72 NA 51.5 0.53 1,2 0,00 26,350 A Repair finger/hand tendon 6,07 NA 11.05 0.83 1,2 0,00 26,356 A Repair finger/hand tendon 10,22 NA 11.87 1.16 1,4 0,00 26,373 A Repair finger/hand tendon 8,65 NA 12.31 1.29 1,4 0,00 26,373 A Repair finger/hand tendon 8,65 NA 12.31 1.29 1,4 0,00 26,373 A Repair finger/hand tendon 8,85 NA 12.31 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.31 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 0,00 26,373 A Repair finger/hand tendon 8,89 NA 12.4 1.34 1,4 1,4 1,4 1,4 1.24 1,5 1,5 1,5 1,5 1,5 1,5 1,5 1,6 1,6 1,6 1,5 1,5 1,5 1,7 1,6 1,6 1,5 1,5 1,5 1,8 1,9 1,5 1,5 1,5 1,9 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,5 1,5 1,0 1,0 1,0 1,0 1,0 1,5 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0 1,0	A Drainage A Drainage A A Drainage A A Drainage A A Drainage A Drainage A A Treat hance A A Decompre A A Decompre A A Release po A A Release po A A Incise fing A A Incise fin	n or wrist surgery		0.00	0.00	0.00	AAA	26260	∢ ·	Extensive inger surgery	7.09	۲ : ۲ :	/ (00	90.0	260
1,000 1,00	A Drainage A Drainage A Drainage A Drainage A Trainage A Drainage A Decomptor A Decomptor A Release pa A Release pa A Incison o Toodes and descriptions	e of finger abscess		4.78	1.85	0.17	010	26261	∢ •	Extensive tinger surgery	87.5	V Z	£.5	787	26
100 100	A Drain han A Drainage - A Drainage - A Drainage - A Treat han A Decompre A Decompre A Release pa A Release pa A Inciston o A Inciston o Todes and descriptions	e of finger abscess	2.21	7.25	2.39	0.29	010	70707	∢ •	Farual removal of imager	3.12	4 5	70.5	0.00	260
100 200	A Drainage A A Treat band A Decompre A Decompre A Decompre A Release p A Release p A Incise fing A Incise of the post of the p	and tendon sheath	4.97	AN .	5.70	60.0	060	07597	€ <	Manipulate Green wonesth	4.02	ζ V V	5.35	0.33	060
100 100	A Uratabace A Decompre A Decompre A Decompre A Release pa A Release pa A Incise fing A Incision o T codes and descriptions	e of palm bursa	4.99	K Z	3.47	60.0	060	26350	< <	Densit fings/hand tendon	20:7	C A	11.05	0.83	060
1,000 1,00	A Treat nance A Decompre A Decompre A Release p A Release p A Release p A Incisefing A Inciseror T codes and descriptions	e of pairth oursa(s)	0.10	V.	0.00	0.00	060	26367	(⊲	Repair anger unan tendan	7.75	NA.	11.87	91	060
10	A Decompre A Decompre A Release p A Release p A Incise fing A Incise on O T codes and descriptions	ind bone lesion	71.5	۲×.	7/70	1.67	060	95196	. 4	Renair finger/band tendon	10.22	NA N	16.04	141	060
1,23 1,24 1,25	A Release py A Release py A Release py A Incise fing A Incise on o T codes and descriptions	ress tingers/hand	11.14	Y X	40.4	0.0	060	26330	< ⊲	Repair finger/hand tendon	8 65	Y N	12.31	1.29	060
1.25 0.00	A Release pa A Release pa A Incise fing A Incision o Codes and descriptions	Mess imgers/nam	00.0	4.7	7.70	24.0	000	2635	: <	Densit/oraft hand tendon	0 22	· Z	12.88	0.87	060
2070 A Repair ingerthand tendon 8.19 NA 12.14 1.34 1.40 090 26372 A Repair graft band tendon 8.29 NA 12.14 1.24 1.41 090 26373 A Repair finger/hand tendon 8.29 NA 12.14 1.24 1.42 090 26373 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a coursely to the general public and are not used for Medicare payment. 3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the files used for Medicare payment. 4 Medicare payment. 4 Cibbal tools for malpractice RVUs may not sum due to rounding.	A Release por A Tree of Ting A Trocks and descriptions or reved.	paim contracture	3.38	¢ ;	4.30	500	060	95502	(<	Domeir Green/head tender	11.	4 12	11.75	101	000
141 090 20314 A Repair fuger/band tendon 8.29 NA 12.14 1.24 150 090 26373 A Repair fuger/band tendon 8.29 NA 12.14 1.24 1 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 1 Reserved. 1 Reserved. 2 Reserved. 2 Reserved. 3 Reserved. 3 Reserved. 3 Reserved. 3 Reserved. 4 Reserved. 5 Reser	A Incise fing A Incision o A codes and descriptions sived.	palm contracture		A S	3.83	0.82	060	70310	۲ -	Repair imperinant tendon	11.7	Ć <	13.43	133	000
CPT codes and descriptions only are copyright 2009 American Medical Association. A Repair Higher hadden tendon 0.29 N. C.	A Incision o T codes and descriptions rived.	inger tendon sheath		10.44	4.52	0.41	060	7/507	< -	Repair grait name tendon	0.00	V.V.	C#.71	27	000
lor CPT	T codes and descriptions rved.	of finger tendon	2.85	Y.	3.08	0.40	060	_	A	Nepau imgel/udud tendon	0.47	A Accompanie	All Dioke	1	3
for CPT	atons are reflected for co	nts only are copyright 2009 Ame	erican Medica	II ASSOCIATIO	n. Au Kuga.	2		, 9 <u>8</u>	served.	descriptions only are copyright 2003 of	TIMES IN THE STATE OF THE STATE	icai 75390 laur	ii. An idea		
for CPT		codes not payable by Medicare,	, please note th	hat these val	ues bave ber	en		1 ₂	f values are re	effected for codes not payable by Medic	are, please not	e that these va	lues have be		
for CPT	lished as a courtesy to the	the general public and are not to	used for Medic	care paymen	ن			621	ablished as a	courtesy to the general public and are n	tot used for Me	dicare paymen	H.		
	budget neutrality reduc	uction from the chiropractic den	nonstration is	not reflected	in the RVC	Js for CPT		Γ. 6	he budget ne	utrality reduction from the chiropractic and 08042. The required reduction	demonstration n will only be	is not reflecte	d in the KVL e files used fo	s for CP-1	
nahmaetice RVI is may not sum due to rounding.	98940, 98941, and 985	8942. The required reduction w	viii oniy be rei	necica in me	THES TREET	5		3 🗵	edicare paym	ent.	and man in	m managem			
	care payment. hai totais for mainraetie	ice RVI is may not sum due to r	ounding					*	lobal totals f	or malpractice RVUs may not sum due	to rounding.				

² If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
² The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.
⁴ Global totals for malpractice RVUs may not sum due to rounding.

CPT ⁽³⁾				Physi- cian Work	Non- Facility PE	Facility	Mal- Practice		CP473/			Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	
HCPCS	Mod	Status	Description	RVU	RVUs.	RVUe	RVUs"	Global	HCPCS Mod	d Status	Description	KVOR.	SOA A	**************************************	KVU8	000
26390		ď	Revise hand/finger tendon	15.6	ď.	10.92	96,1	060	01607	< -	Fusion of knuckle joint	17.7	ξ ;	¥0.64	0.90	060
26392		∢:	Repair/graft hand tendon	10.38	ΥN	13.16	(2)	060	/1507	<	rusion of knuckle joints	8.90	Z.	10.90	1.34	080
26410		4	Repair hand tendon	4.68	٧Z	8.93	99.0	060	26518	∢	Fusion of knuckle joints	9.15	Υ Z	90.	1.37	060
26412		ď	Repair/graft hand tendon	6.37	NA	10.14	0.85	060	26520	۷	Release knuckle contracture	5.36	ΥZ	10.34	0.73	060
26415		4	Excision, hand/finger tendon	8.40	NA	8.97	0.85	060	26525	4	Release finger contracture	5.39	∢ Z	10.34	0.71	060
26416		∢	Graft hand or finger tendon	9.44	NA	11.95	1.4	060	26530	٧	Revise knuckle joint	91.9	ΝΑ	6.51	0.92	060
26418		*	Repair finger tendon	4.33	NA	9.46	0.61	060	26531	∢	Revise knuckle with implant	7.99	ΥZ	7.50	1.04	060
26420		∢	Repair/graft finger tendon	6.83	۷ Z	10.45	1.02	060	26535	4	Revise finger joint	5.30	٧X	5.05	19.0	060
26426		<	Repair finger/band tendon	6.21	Ν	81.9	0.85	060	26536	4	Revise/implant finger joint	6.44	Ϋ́N	10.86	0.83	060
26428		•	Repair/graft finger tendon	7.28	AN	10.89	1.09	060	26540	×	Repair hand joint	6.49	NA NA	9.47	0.88	060
26432		∢	Repair finger tendon	4.07	NA	7.95	0.55	060	26541	*	Repair hand joint with graft	8.69	ΝA	10.92	1.12	060
26433		4	Repair finger tendon	4.61	NA	8.17	0.64	060	26542	4	Repair hand joint with graft	6.84	NA	9.46	0.94	060
26434		٧	Repair/graft finger tendon	6.15	ΝA	9.36	0.92	060	26545	*	Reconstruct finger joint	66.9	NA	9.94	0.94	060
26437		٧	Realignment of tendons	5.88	N'A	9.16	0.77	060	26546	¥	Repair nonunion hand	10.53	NA	13.30	1.38	060
26440		<	Release palm/finger tendon	5.07	ΝA	9.90	19'0	060	26548	V	Reconstruct finger joint	8.10	ΝA	10.40	1.10	060
26442		<	Release palm & finger tendon	9.50	NA	13.87	1.29	060	26550	V	Construct thumb replacement	21.54	ΝΑ	18.80	3.22	060
26445		<	Release hand/finger tendon	4.36	NA	9.54	0.59	060	26551	¥	Great toe-hand transfer	48.23	Ϋ́	33.56	7.22	060
26449		<	Release forearm/hand tendon	8.34	NA	8.78	1.12	060	26553	Y	Single transfer, toe-hand	47.92	NA	23.97	2.57	060
26450		∢	Incision of palm tendon	3.71	ΑN	6.13	0.52	060	26554	٧	Double transfer, toe-hand	56.73	Ϋ́Z	27.52	3.04	060
26455		K	Incision of finger tendon	3.68	NA	6.05	0.51	060	26555	¥	Positional change of finger	16.94	NA	17.43	2.54	060
26460		٧	Incise hand/finger tendon	3.50	N.	5.97	0.46	060	26556	٧	Toe joint transfer	49,43	NA	13.79	6.60	060
26471		4	Fusion of finger tendons	5.79	NA	9.11	0.77	060	26560	٧	Repair of web finger	5.43	NA	8.57	0.81	060
26474		۷	Fusion of finger tendons	5.38	NA	86.8	0.81	060	26561	¥	Repair of web finger	10.98	NA	66.6	1.78	060
26476		∢.	Tendon lengthening	5.24	NA	8.91	0.78	060	26562	¥	Repair of web finger	16.40	ΝA	11.37	0.88	060
26477		ĸ	Tendon shortening	5.21	Ϋ́	8.85	97.0	060	26565	4	Correct metacarpal flaw	6.80	NA	9.65	1.02	060
26478		∢	Lengthening of hand tendon	5.86	ΝA	6.17	0.82	060	26567	¥	Correct finger deformity	6.88	ΝΑ	69'6	0.92	060
26479		∢	Shortening of hand tendon	5.80	ΝA	61.6	0.87	060	26568	¥	Lengthen metacarpal/finger	9.15	Y.	12.56	1.37	060
26480		4	Transplant hand tendon	6.76	NA	11.32	06'0	060	26580	V	Repair hand deformity	19.50	Z Z	17.40	26.2	060
26483		<	Transplant/graft hand tendon	8.36	NA	11.93	1.18	060	26587	Ą	Reconstruct extra finger	14.36	NA	9.17	2.33	060
26485		٧	Transplant palm tendon	7.77	NA	11.78	1.05	060	26590	¥	Repair finger deformity	18.51	٧X	15.96	2.77	060
26489		٧	Transplant/graft palm tendon	9.74	ΝA	12.85	1.46	060	16592	Ą	Repair muscles of hand	3.30	N.A	7.03	0.45	060
26490		ď.	Revise thumb tendon	8.48	NA	10.73	1.07	060	26593	¥	Release muscles of hand	5.38	ΝΑ	9.17	69.0	060
26492		V	Tendon transfer with graft	9.70	NA	19:11	1.45	060	26596	¥	Excision constricting tissue	9.02	NA A	9.49	1.35	060
26494		∢	Hand tendon/muscle transfer	8.54	NA	10.76	1.28	060	26600	¥	Treat metacarpal fracture	2.48	4.57	4.16	0.35	060
26496		∢	Revise thumb tendon	99'6	ď	11,43	1.25	060	20992	∢	Treat metacarpal fracture	2.92	4.84	4.17	0.41	060
26497		٧	Finger tendon transfer	9.64	ΑN	11.30	1,44	060	26607	٧	Treat metacarpal fracture	5.40	N A	5.77	0.78	060
26498		¥	Finger tendon transfer	14.07	NA	13.76	2.14	060	26608	<	Treat metacarpal fracture	5.43	NA A	6.26	0.77	060
26499		٧	Revision of finger	9.05	NA	10.11	1.35	060	20012	¥	Treat metacarpal fracture	16'9	Y.Z	7.22	96'0	060
26500		∢	Hand tendon reconstruction	6.02	NA	9.14	0.85	060	26641	¥	Treat thumb dislocation	4.01	4.98	4.22	0.53	060
26502		V	Hand tendon reconstruction	7.20	NA	88.6	80.1	060	26645	A	Treat thumb fracture	4.47	5.87	5.04	79'0	060
26508		V	Refease thumb contracture	6.07	N.	9,02	16.0	060	26650	۷	Treat thumb fracture	5.19	٧Z	6.45	0.74	060
26510		¥	Thumb tendon transfer	5.49	ΝA	8.94	0.70	060	26665	٧	Treat thumb fracture	7.78	Y.	7.70	1.09	060
	CPT co	odes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	lical Associa	ttion. All Ri	ghts		ਹੈ -	T codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associati	ion. All Rigl	ıts	
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	· If value	es are re-	" It values are reflected for codes not payable by Medicare, please note that to probablished as a coverage to the general public and are not used for Medicare	are, please no.	te that these	these values have been	Deen		III	values are rel	. If values are reflected for codes not payable by Miedicare, please note that these values have been setablished as a courteeu to the general mubilic and are not used for Medicare payment.	re, piease nou	e mar mese v	aines nave n	nea:	
	The but	dget neu	The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not refle	cted in the R	VUs for CPT		aT.	e budget neu	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	emonstration	is not reflect	ed in the RV	Us for CPT	
	codes 98	3940, 985	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be	reflected in	the files use	l for		apoo	s 98940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in th	pe files used	for	
	Medican	Medicare payment	int.	:					Med	dedicare payment	ot.					
	Clobat	totals to	Colobal totals for malpractice RVUs may not sum due to rounding	o rounding.					รั	obai totais ro	Global totals for mappractice $K \vee U S$ may not sum due to rounding.	o roundung.				

90 900 7000 A Incision of thip encided 55.6 NA 63.0 103 170 90 27001 A Incision of thip enciden 75.6 NA 63.0 11.5 180 900 27003 A Incision of thip enciden 70.6 NA 63.0 11.5 180 900 27005 A Incision of thip enciden 70.6 NA 63.1 10.9 270 900 27005 A Incision of thip pinal 11.246 NA 63.1 10.1 270 900 27005 A Burnet, kenemany of thip joint 11.249 NA 63.1 10.1 270 900 27005 A Burnet, kenemany of thip joint 11.24 NA 63.1 10.0 270 900 27014 A Burnet, kenemany of thip joint 11.21 NA 10.7 10.0 270 900 2704 A Burnet, kenemany of thip joint 11.2 NA 11.6 10.2 270 900 2704 A Rumer,	1	Š	9	Description	Physi- clan Work RVIIs ²³	Non- Facility PE RVIIs ^{2,3}	Facility PE PE 8VIIs 23	Mal- Practice	Global	CPT ¹⁵ /PCS Mod	Status	Description	Physician cian Work RVUs ^{2,3}	Non- Facility PE RYUS ^{2,3}	Facility PE RVUs ^{2,3}	Mal- Practice RVUs 2 3 4	Global
777 770 A Incision of this pendum 710 A 6.3 1.15 778 900 27073 A Incision of the pendum 710 NA 6.3 1.15 788 900 27073 A Incision of the pendum 9.8 NA 6.3 1.14 788 900 27073 A Incision of the pendum 9.8 NA 6.3 1.14 788 900 27073 A Damerica of the pendum 1.24 NA 6.34 1.14 789 900 27073 A Damerica of the pendum 1.25 NA 6.3 1.14 787 900 27073 A Damerica of the pendum 1.25 NA 6.3 1.14 787 900 27074 A Damerica of the pind muscle 1.25 NA 6.3 1.14 784 900 27074 A Damerica pendum 1.24 NA 6.3 1.13 <t< th=""><th>7.9 10.0 1.0<!--</th--><th>.</th><th>-</th><th>Description Treat hand dislocation</th><th>3.74</th><th>4 40</th><th>3 60</th><th>040</th><th>060</th><th></th><th>4</th><th>Incision of hin tendon</th><th>5.66</th><th>Ϋ́</th><th>5.06</th><th>0.79</th><th>060</th></th></t<>	7.9 10.0 1.0 </th <th>.</th> <th>-</th> <th>Description Treat hand dislocation</th> <th>3.74</th> <th>4 40</th> <th>3 60</th> <th>040</th> <th>060</th> <th></th> <th>4</th> <th>Incision of hin tendon</th> <th>5.66</th> <th>Ϋ́</th> <th>5.06</th> <th>0.79</th> <th>060</th>	.	-	Description Treat hand dislocation	3.74	4 40	3 60	040	060		4	Incision of hin tendon	5.66	Ϋ́	5.06	0.79	060
90 27003 A Incision of this pendom 970 A Incision of this pendom 970 A Incision of this pendom 970 NA 812 149 212 900 27008 A Incision of this pendom 990 NA 812 149 213 900 27003 A Incision of this pendom 1296 NA 913 049 213 900 27003 A Incision of this point 1296 NA 913 049 213 900 27003 A Incision of this point 1296 NA 913 049 213 900 27003 A Incision of this point 1236 NA 913 049 213 900 27004 A Incision of this point 173 NA 173 049 214 900 27004 A Incision of this point mine 173 NA 173 170 170 170 170 170 <t< td=""><td>779 OH TOTOS A Incresson of this pendon 770 A Incresson of this pendon 90 NA 815 149 220 000 2700S A Incresson of this pendon 99 NA 812 149 230 000 2700S A Incresson of this pendon 129 NA 918 101 231 000 2700S A Incresson of this pendon 1290 NA 918 101 232 000 2700S A Damera benon of this pendon 1290 NA 918 06 232 000 2700S A Damera benon of this pendon 1290 NA 918 101 232 000 2700S A Damera benon of this pendon 129 NA 120 100 233 000 2700S A Damera benon of this pendon 129 NA 120 100 234 000 2700S A Damera benon of this p</td><td>(⊲</td><td>-</td><td>Treat hand dislocation</td><td>4.71</td><td>6.23</td><td>5.41</td><td>0.70</td><td>060</td><td>27001</td><td>< <</td><td>Incision of hip tendon</td><td>7.05</td><td>₹ Z</td><td>6.30</td><td>1.05</td><td>060</td></t<>	779 OH TOTOS A Incresson of this pendon 770 A Incresson of this pendon 90 NA 815 149 220 000 2700S A Incresson of this pendon 99 NA 812 149 230 000 2700S A Incresson of this pendon 129 NA 918 101 231 000 2700S A Incresson of this pendon 1290 NA 918 101 232 000 2700S A Damera benon of this pendon 1290 NA 918 06 232 000 2700S A Damera benon of this pendon 1290 NA 918 101 232 000 2700S A Damera benon of this pendon 129 NA 120 100 233 000 2700S A Damera benon of this pendon 129 NA 120 100 234 000 2700S A Damera benon of this p	(⊲	-	Treat hand dislocation	4.71	6.23	5.41	0.70	060	27001	< <	Incision of hip tendon	7.05	₹ Z	6.30	1.05	060
(1) (1) <td>100 700 A Incision of the pendan 9.96 NA 8.15 147 101 900 2700 A Incision of the pendant 9.96 NA 8.14 147 101 900 2700 A Damace Amphight face 1266 NA 9.18 191 201 900 2700 A Damace Amphight face 1266 NA 9.18 191 201 900 2700 A Damace Amphight face 1266 NA 9.18 191 202 900 2700 A Damace Amphight face 1264 NA 9.19 100 203 900 2700 A Damace Amphight face 1264 NA 9.19 100 204 900 2700 A Damace Amphight face 1264 NA 127 100 204 900 2700 A Borgov of call fissues 100 NA 120 100 205 900 2700 A Borgov of call fissues 100 NA 120</td> <td>: ⊲</td> <td></td> <td>Pin hand dislocation</td> <td>1 60</td> <td>NA</td> <td>6.64</td> <td>0.78</td> <td>060</td> <td>27003</td> <td>₹</td> <td>Incision of hip tendon</td> <td>7.70</td> <td>Ϋ́Z</td> <td>6.93</td> <td>1.15</td> <td>060</td>	100 700 A Incision of the pendan 9.96 NA 8.15 147 101 900 2700 A Incision of the pendant 9.96 NA 8.14 147 101 900 2700 A Damace Amphight face 1266 NA 9.18 191 201 900 2700 A Damace Amphight face 1266 NA 9.18 191 201 900 2700 A Damace Amphight face 1266 NA 9.18 191 202 900 2700 A Damace Amphight face 1264 NA 9.19 100 203 900 2700 A Damace Amphight face 1264 NA 9.19 100 204 900 2700 A Damace Amphight face 1264 NA 127 100 204 900 2700 A Borgov of call fissues 100 NA 120 100 205 900 2700 A Borgov of call fissues 100 NA 120	: ⊲		Pin hand dislocation	1 60	NA	6.64	0.78	060	27003	₹	Incision of hip tendon	7.70	Ϋ́Z	6.93	1.15	060
2.2. 9.00 27006 A incision of this inequals 9.90 NA 9.81 1.91 9.01 9.02 27022 A Barneck becidenty 12.90 NA 9.81 1.91 2.21 9.00 27023 A Darnage of this point 12.90 NA 9.81 0.60 2.22 9.00 27023 A Darnage of this point 12.90 NA 10.20 2.00 2.22 9.00 27026 A Darnage of this point muse 18.80 8.92 1.00 2.00 2.22 9.00 27044 A Darnage of this point muse 18.90 NA 1.20 1.00 2.22 9.00 27044 A Darnage of this point muse 18.90 NA 1.51 1.00 2.22 9.00 27044 A Remove of this point muse 1.81 NA 1.51 1.00 2.22 9.00 27044 A Remove thim this point ime 1.00 NA	2.2 900 77000 A Incision of thip fundadus 990 NA 8.1 147 2.3 900 77000 A Incision of thip fundations 15.9 NA 9.8 149 2.3 900 27027 A Dataset of thip joint 15.9 NA 9.18 10.0 2.3 900 27028 A Dataset of thip joint 15.9 NA 10.20 2.0 2.3 900 27028 A Dataset of thip joint 15.9 NA 10.20 2.0 2.3 900 27024 NA Explanation of thip joint 15.3 NA 10.20 2.0 2.3 900 27024 A Explanation of thip joint mines 10.0 10.0 10.0 2.3 900 27024 A Burney of facilities 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 10.0 <	: 4		Frest hand dislocation	691	ĄZ	7.21	1.03	060	27005	Ą	Incision of hip tendon	96.6	Ϋ́Z	8.05	1.49	060
90 27025 A intricein of thing thing flaces 1266 NA 9.84 190 210 90 27025 A intricein of thing thing flaces 1296 NA 9.18 109 217 90 27030 A Demarge of thing joint 13.94 NA 10.20 209 217 200 27033 A Demarge of thing joint 17.23 NA 10.23 209 217 200 27034 A Borgo of soft lissues 18.94 NA 10.20 238 224 200 27044 A Borgo of soft lissues 10.77 NA 10.20 238 226 200 27044 A Borgo of soft lissues 10.77 NA 10.77 209 226 200 27044 A Borgo of soft lissues 10.77 NA 13.8 10.77 10.00 11.8 226 200 27044 A Remove limpted listue 17.27 NA 13.6 13.6 227 200 27040 A Remove	90 27072 A incision of thip flight fister 12.66 N A 918 109 217 90 27073 A Direction of thip point 13.54 NA 918 0.09 217 90 27033 A Directivo flop joint 13.54 NA 918 2.09 217 90 27033 A Directivo flop joint 13.54 NA 10.20 2.09 217 90 27040 A Directivo flop joint 17.23 NA 10.20 2.09 217 90 27040 A Directivo flop joint flop in thin point flow flow 17.23 NA 1.35 2.09 2.09 213 90 27044 A Remove lipipeix lesson 1.07 NA 9.20 1.09 1.38 214 90 27044 A Remove lipipeix lesson 1.04 NA 9.21 1.09 1.13 1.18 214 90 27044 A Remove lipipeix lesson 1.04 NA 8.21 1.09 1.18 1.09	: ∢		Treat hand dislocation	8.06	Ν	7.25	1.21	060	27006	٧	Incision of hip tendons	66.6	Ϋ́Z	8.21	1.47	060
900 27027 A Darange of the joint 12.94 NA 9.15 0.06 201 900 27033 A Darange of the joint 13.94 NA 9.15 0.06 204 200 27033 A Exploration of the joint missues 1.39 NA 10.20 2.09 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 2.09 1.30 1.30 2.09 1.30 1.30 2.09 1.31 2.09 1.31 2.09 1.31 2.09 1.30 2.09 1.31 2.09 1.31 2.09 1.31 2.09 1.31 2.09 2.31 2.09 2.31 2.09 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.31 2.09 2.	90 27027 A Darrange of the piont 12.94 NA 9.15 0.06 373 0.00 27033 A Darrange of the piont 13.94 NA 9.13 0.00 373 0.00 27033 A Darrange of the piont 11.95 NA 10.20 2.00 374 0.00 27034 A Darrange of the piont 11.95 NA 10.20 2.09 374 0.00 27034 A Darrange of the piont 11.95 NA 10.20 2.09 374 0.00 27044 A Darrange of the piont 11.95 NA 1.30 2.09 373 0.00 27044 A Barrange of the piont 11.41 NA 6.07 1.09 1.00 373 0.00 27044 A Recover hippotic site site on 1.41 NA 5.13 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	: ∢		Treat knuckle dislocation	3.74	4.05	3.60	0.48	060	27025	4	incision of hip/thigh fascia	12.66	ΥN	9.84	16.1	060
99 27/39 A Danage of the joint 1354 NA 9.81 2.00 222 999 27/33 A Danage of the joint 1399 NA 10.20 2.88 224 999 27/33 A Danage of the joint 117.8 NA 10.71 2.89 274 999 27/34 A Biopsy of soft fissars 2.89 5.52 2.99 6.33 274 990 27/34 A Biopsy of soft fissars 10.07 NA 6.65 1.18 275 990 27/34 A Remove lapports issue 6.44 NA 6.65 1.18 274 990 27/34 A Remove lapports issue 6.44 NA 6.51 1.00 275 A Remove lapports issue 6.44 NA 6.83 1.10 275 A Remove lapports issue 6.44 NA 6.83 1.10 275 A Remove lapports issue 6.44 NA 6.83 1.10 275 A Remove lapports issue 6.	900 27000 A Exploration of this joint 13.49 NA 9.81 2.00 222 900 27035 A Exploration of this joint 13.29 NA 10.20 2.90 223 900 27035 A Exploration of this joint insist 14.18 NA 10.20 2.90 224 900 27040 A Excision of this joint insist 14.18 NA 10.71 2.90 225 900 27041 A Excussion of this joint insist 16.4 NA 10.71 13.6 226 900 27044 A Excussion of this joint insist 16.4 NA 5.55 1.00 226 900 27048 A Remove this pict is tested 16.4 NA 6.51 1.18 226 900 27050 A Remove this pict is tested 14.7 NA 6.51 1.16 226 900 27050 A Remove this pict is tested 14.7 NA 6.51 1.18 226 900 27050 A Remove th	. ∢	,	Treat knuckle dislocation	4.26	5.85	5.00	0.61	060	27027	٧	Buttock fasciotomy	12.90	Ϋ́Z	9.15	69.0	060
99 27033 A Experiention of hip joint 113.99 NA 10.20 2.08 24.7 999 27035 A Descrivation of hip joint 17.21 NA 10.20 2.08 24.7 999 27046 A Biopsy of soft itssues 10.01 NA 6.63 1.36 25.6 990 27041 A Remove hippelvis lesson 1.51 NA 6.63 1.36 25.6 990 27042 A Remove hippelvis lesson 6.44 NA 6.63 1.00 25.3 990 27049 A Remove himpelvis lesson 6.44 NA 5.15 1.00 25.4 990 27049 A Remove lipholic lesson 7.27 NA 6.85 1.00 25.6 990 27054 A Remove lipholic lesson 7.27 NA 6.85 1.00 25.6 990 27054 A Remove lipholic lesson 7.27 NA 6.85 1.00 25.6 990 27055 A Remove lipholic lesson 7.27<	990 27033 A Depending of this joint 1359 NA 1023 238 247 909 27036 A Devention of this joint muscle 14.18 NA 1027 2.88 247 909 27036 A Borpsy of soft issues 2.89 2.90 1.36 248 909 27040 A Borpsy of soft issues 1.81 NA 1.07 2.99 233 909 27040 A Remove imprefix lesion 7.51 NA 5.65 1.18 244 909 27049 A Remove imprefix lesion 6.44 NA 5.65 1.18 243 909 27049 A Remove imprefix lesion 6.44 NA 5.65 1.18 244 909 27050 A Remove imprefix lesion 7.51 NA 5.10 0.75 244 909 27050 A Remove imprefix lesion 7.21 NA 5.13 1.00 245 909 27050 A Remove imprefix lesion 7.22 NA <td< td=""><td><</td><td></td><td>Pin knuckle dislocation</td><td>5.19</td><td>NA</td><td>5.63</td><td>0.71</td><td>060</td><td>27030</td><td>٧</td><td>Drainage of hip joint</td><td>13.54</td><td>ΥN</td><td>9.8</td><td>2.01</td><td>060</td></td<>	<		Pin knuckle dislocation	5.19	NA	5.63	0.71	060	27030	٧	Drainage of hip joint	13.54	ΥN	9.8	2.01	060
940 27035 A Description of the point mascle 1723 NA 12.03 238 174 969 27046 A Bioppy of soft issues 178 NA 107 2.09 0.33 174 969 27044 A Bioppy of soft issues 1007 NA 6.65 1.18 253 969 27044 A Remove hippoths issue 1007 NA 5.63 1.09 254 969 27049 A Remove hippoths issue 644 NA 5.63 1.00 254 969 27049 A Remove hippoths issue 644 NA 5.15 0.75 254 969 27054 A Remove them belong them	9.9 27035 A Excision of this joint mascle 17.23 NA 12.03 2.98 2.74 809 27046 A Excision of this joint mascle 14.8 NA 10.79 2.09 0.33 2.75 809 27041 A Biopsy of soft itsease 1.89 NA 6.65 1.18 2.75 809 27044 A Biopsy of soft itsease 1.00 8.49 5.65 1.18 2.75 809 27048 A Remove lappeds itsean 6.44 NA 6.55 1.18 3.44 909 27048 A Remove lappeds itsean 6.44 NA 6.85 1.18 3.45 909 27052 A Remove lappeds itsean 6.44 NA 6.85 1.10 3.45 909 27052 A Remove lapped itsean 7.77 NA 6.85 1.10 3.45 909 27052 A Remove lapped itsears 7.78 NA 6.	. 4		Treat knuckle dislocation	6.87	NA	7.13	0.97	060	27033	<	Exploration of hip joint	13.99	NA	10.20	5.09	060
940 27046 A Excision of this joint/muscle 14.18 NA 10.77 2.09 213 990 27040 A Biopsy of soft issues 2.89 5.52 2.99 1.36 213 990 27041 A Remove hippelvis lesion 6.44 NA 6.65 1.18 214 990 27043 A Remove hippelvis lesion 6.44 NA 5.65 1.18 214 990 27049 A Remove hippelvis lesion 6.44 NA 5.65 1.18 214 990 27049 A Remove huppelvis lesion 6.44 NA 5.15 1.00 214 990 27052 A Remove four leinburs 5.09 NA 5.15 1.00	44.18 909 27046 A Biopsy of soft itssues 14.18 A Dispy of soft itssues 14.18 A Dispy of soft itssues 18.99 SS 22 2.09 2.03 1.25 909 27044 A Biopsy of soft itssues 1.07 8.49 5.56 1.18 3.33 909 27047 A Remove lipipote's itssue 6.44 NA 6.65 1.16 2.44 909 27049 A Remove lipipote's itssue 6.44 NA 6.55 1.10 2.44 909 27050 A Remove lipipote's itssue 6.44 NA 6.85 1.00 2.44 909 27050 A Remove lipipote's itssue 7.27 NA 6.85 1.00 2.40 909 27050 A Remove lipipote's itssue 7.27 NA 1.16 0.95 2.40 909 27050 A Remove lipipote's itssue 7.27 NA 1.16 0.95 1.16 0.95 1.16 0.95 1.16 0.95 1.16 0.95 1.16	< <	-	Freat finger fracture, each	1.70	3.07	2.75	0.23	060	27035	٧	Denervation of hip joint	17.23	NA	12.03	2.58	060
99 27040 A Biopsy of soft itssues 189 52 20 0.33 212 99 27041 A Remove hippelvis basion 6.44 NA 6.65 1.18 213 990 27047 A Remove hippelvis basion 6.44 NA 6.65 1.18 213 990 27048 A Remove hippelvis basion 6.44 NA 6.65 1.18 214 990 27049 A Biopsy of the pipel 15.20 NA 6.81 1.00 214 990 27050 A Biopsy of the pipel 7.87 NA 6.81 1.00 215 990 27050 A Removal of hip book pipel 7.78 NA 6.84 1.04 0.87 215 990 27057 A Removal of hip book pipel 7.78 NA 6.84 1.04 0.87 215 990 27067 A Removal of hip book besion 1.14 NA 6.44 NA 6.92 2.09 0.37 215 990	90 27040 A Biopsy of soft itssues 189 55.2 20 0.33 134 909 27041 A Biopsy of soft itssues 10.7 NA 665 1.18 333 909 27041 A Remove thippets is shown 6.44 NA 6.65 1.18 343 909 27049 A Remove thippets is shown 6.44 NA 6.65 1.18 343 909 27040 A Biopsy of strought in thippets is shown 6.44 NA 6.65 1.18 1.00 344 909 27040 A Biopsy of thippient 727 NA 6.85 1.00 340 909 27054 A Removed the imploint image 9.99 NA 7.34 1.00 340 909 27067 A Biopsy of thip iont image 9.99 NA 4.64 NA 4.64 1.10 340 909 27067 A Removed of thip bone kiston 4.47 NA 4.64 1.10 1.10 340 909	<	, -	Treat finger fracture, each	3.39	4.85	4.08	0.47	060	27036	¥	Excision of hip joint/muscle	14.18	Ϋ́Z	10.77	5.09	060
(1) (1) <td>1.00 27041 A Boysy of soft itsians 10.07 NA 6.65 1.18 2.20 27043 A Remove hippelvis beion 751 8.49 5.66 1.18 2.20 27043 A Remove hippelvis beion 6.44 NA 5.60 1.00 2.21 8.90 27048 A Remove hippelvis beion 6.44 NA 5.65 1.00 2.22 9.90 27049 A Removed from the man, hippelvis beion 6.44 NA 5.15 1.00 2.22 9.90 27046 A Removal of hippelvis beion 4.65 NA 5.15 1.00 2.22 1.00 A Removal of hippelvis beion 4.65 NA 5.14 1.16 2.20 1.00 2.00 A Removal of hippelvis beion 4.65 NA 5.52 1.15 2.20 1.00 2.00 A Removal of hippelvis beion 4.77 NA 4.64 8.8 1.10 2.20 1.00 2.00 A Removal of hippelvis beion 4.04</td> <td></td> <td>,</td> <td>Treat finger fracture, each</td> <td>5.30</td> <td>NA</td> <td>6.20</td> <td>0.74</td> <td>060</td> <td>27040</td> <td><</td> <td>Biopsy of soft tissues</td> <td>5.89</td> <td>5.52</td> <td>2.09</td> <td>0.33</td> <td>010</td>	1.00 27041 A Boysy of soft itsians 10.07 NA 6.65 1.18 2.20 27043 A Remove hippelvis beion 751 8.49 5.66 1.18 2.20 27043 A Remove hippelvis beion 6.44 NA 5.60 1.00 2.21 8.90 27048 A Remove hippelvis beion 6.44 NA 5.65 1.00 2.22 9.90 27049 A Removed from the man, hippelvis beion 6.44 NA 5.15 1.00 2.22 9.90 27046 A Removal of hippelvis beion 4.65 NA 5.15 1.00 2.22 1.00 A Removal of hippelvis beion 4.65 NA 5.14 1.16 2.20 1.00 2.00 A Removal of hippelvis beion 4.65 NA 5.52 1.15 2.20 1.00 2.00 A Removal of hippelvis beion 4.77 NA 4.64 8.8 1.10 2.20 1.00 2.00 A Removal of hippelvis beion 4.04		,	Treat finger fracture, each	5.30	NA	6.20	0.74	060	27040	<	Biopsy of soft tissues	5.89	5.52	2.09	0.33	010
90 27047 A Remove hippelvis fesion 751 8.49 5.66 11.8 23 90 27048 A Remove hippelvis fesion 6.44 NA 5.53 10.0 24 900 27049 A Remove hippelvis fesion 6.44 NA 5.51 0.75 34 900 27052 A Blopsy of Play joint lining 72 NA 5.15 0.75 55 900 27054 A Removal of hip joint lining 9.90 NA 7.84 1.36 50 90 27055 A Butosy of Play joint lining 7.72 NA 7.84 1.36 50 90 27066 A Removal of hip bone bisson 6.44 NA 5.15 0.79 50 90 27065 A Removal of hip bone bisson 1.147 NA 1.34 1.16 113 90 27065 A Removal of hip bone bisson 1.147 NA 1.34 1.17<	2.2. 0.90 27.047 A Remove hippelvis lesion 5.4 N.A 5.6 1.18 2.3. 0.90 27.048 A Remove hippelvis lesion 6.44 N.A 5.5 1.18 2.3. 0.90 27.048 A Remove untor hippelvis lesion 6.44 N.A 5.15 0.75 2.3. 0.90 27.05 A Biopsy of the piont 7.2 N.A 6.35 1.09 2.3. 0.90 27.05 A Removal of hip joint 7.2 N.A 6.35 1.05 2.3. 0.90 27.05 A Removal of hip bone lesion 6.44 N.A 6.44 1.05 2.3. 0.90 27.06 A Removal of hip bone lesion 6.44 N.A 6.44 0.3 2.3. 0.90 27.06 A Removal of hip bone lesion 6.44 N.A 6.44 0.3 2.3. 0.90 27.06 A Removal of hip bone lesion 6.44 N.	· «		Treat finger fracture, each	7.26	NA	7.42	1.02	060	27041	٧	Biopsy of soft tissues	10.07	Ϋ́	6.65	1.36	060
93 27048 A Remove thippelvis beston 644 NA 555 150 234 990 27049 A Remove thippelvis 1520 NA 515 150 234 990 27050 A Remove thippelvis 1520 NA 515 0.75 88 990 27057 A Biopsy of sarvidiazioni thing 909 NA 545 100 88 090 27067 A Removal of thip joint thing 909 NA 545 104 0.75 58 090 27067 A Removal of thip joint thing 909 NA 454 0.85 104 0.75 58 090 27062 A Removal of thip joint thing 566 NA 522 0.85 104 0.75 58 090 27062 A Removal of thip joint thing 566 NA 522 0.85 1.95 1.18 1.18 1.18 1.14 NA <t< td=""><td>13.3 999 27048 A Remove thippelvis belon 644 NA 5.55 1.00 2.4.4 990 27049 A Remove thippelvis 15.20 NA 5.15 0.25 2.4.4 990 27052 A Reposy of sarcularis joint lung 9.09 NA 5.15 0.25 2.8.0 990 27053 A Butpoys of sarcularis joint lung 9.09 NA 5.85 1.00 2.8.0 990 27054 A Removal of thip joint lung 9.09 NA 5.85 1.00 2.8.0 990 27065 A Removal of thip joint lung 9.09 NA 5.25 0.85 1.00 2.9.0 990 27065 A Removal of thip joint lung 5.06 NA 5.22 0.85 1.00 0.79 1.00 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.</td><td>. ∢.</td><td>1,</td><td>Treat finger fracture, each</td><td>1.99</td><td>3.54</td><td>3.21</td><td>0.26</td><td>060</td><td>27047</td><td>٧</td><td>Remove hip/pelvis lesion</td><td>7.51</td><td>8.49</td><td>99.5</td><td>1.18</td><td>060</td></t<>	13.3 999 27048 A Remove thippelvis belon 644 NA 5.55 1.00 2.4.4 990 27049 A Remove thippelvis 15.20 NA 5.15 0.25 2.4.4 990 27052 A Reposy of sarcularis joint lung 9.09 NA 5.15 0.25 2.8.0 990 27053 A Butpoys of sarcularis joint lung 9.09 NA 5.85 1.00 2.8.0 990 27054 A Removal of thip joint lung 9.09 NA 5.85 1.00 2.8.0 990 27065 A Removal of thip joint lung 9.09 NA 5.25 0.85 1.00 2.9.0 990 27065 A Removal of thip joint lung 5.06 NA 5.22 0.85 1.00 0.79 1.00 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.79 0.	. ∢.	1,	Treat finger fracture, each	1.99	3.54	3.21	0.26	060	27047	٧	Remove hip/pelvis lesion	7.51	8.49	99.5	1.18	060
131 990 27049 A Remove tumor, hippetvis 15.20 NA 9.92 2.26 3.44 900 27053 A Biopsy of kazordisa joint 4.65 NA 5.15 0.10 3.45 900 27053 A Biopsy of kazordisa joint 4.65 NA 5.15 0.05 3.60 900 27054 A Removal of hip joint liming 9.09 NA 4.64 1.04 0.07 3.01 900 27065 A Removal of hip joint liming 9.09 NA 4.64 0.87 0.85 3.02 900 27065 A Remove formula cisobila bursa 5.78 NA 4.64 0.87 0.85 1.25 900 27066 A Remove formula hip bone basion 11.04 NA 5.40 0.87 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.11 1.1	1.31 990 27049 A Remove tunor, hippetvis 15.20 NA 5.15 0.25 5.44 990 27052 A Biopsy of the joint luning 4.65 NA 5.15 0.05 5.45 990 27054 A Removal of this joint luning 7.27 NA 5.15 0.05 5.46 990 27057 A Removal of this joint luning 9.09 NA 7.44 1.04 0.07 5.40 990 27062 A Removal of fish bone lesson 6.44 NA 5.24 0.85 5.90 990 27066 A Removal of this bone lesson 6.44 NA 5.04 0.87 5.90 990 27066 A Removal of this bone lesson 1.147 NA 9.03 1.14 1.15 090 27067 A Removal of this bone lesson 1.47 NA 9.03 1.14 1.15 090 27070 A Removal of this bone lesson 1.43 NA 1.14 1.14 NA 1.14 1.14	: ∢	-	Treat finger fracture, each	3.90	5.09	4.29	0.53	060	27048	4	Remove hip/pelvis lesion	6.44	Ϋ́Z	5.63	00.1	060
9.0 27050 A Biopsy of sacrolliae joint 465 NA 515 0.75 5.44 900 27054 A Riopsy of five plant liming 7.07 NA 515 1.06 5.64 909 27054 A Removal of hip joint liming 9.09 NA 7.84 1.36 1.04 0.07 5.68 909 27065 A Removal of iskital barsa 5.66 NA 5.24 0.08 5.99 27065 A Removal of iskital barsa 5.66 NA 5.93 0.09 5.90 27065 A Removal of itip bone lesion 14.57 NA 1.04 0.05 1.13 909 27067 A Removal of tip bone lesion 14.57 NA 5.18 1.04 0.05 1.13 909 27067 A Remove long thip bone lesion 14.57 NA 1.03 1.84 1.13 900 27070 A Remil empty of the pone lesion 14.57	2.04 900 2.050 A Biopsy of sarculiae joint 465 NA 5.15 0.75 3.43 900 2.005 A Biopsy of publication 7.27 NA 5.15 0.75 3.60 900 2.005 A Buttoof fischial bursa 5.78 NA 4.64 0.79 3.61 900 2.005 A Buttoof fischial bursa 5.66 NA 5.22 0.85 3.68 900 2.006 A Removal of hip bone lesion 1.06 NA 5.52 0.85 3.09 2.006 A Removal of hip bone lesion 1.45 NA 5.02 0.85 1.15 900 2.007 A Removal of hip bone lesion 1.45 NA 5.18 1.66 1.15 900 2.007 A Removal of hip bone 1.45 NA 1.84 1.84 1.84 1.84 1.13 900 2.007 A Extensive hip surgery 1.42 NA<	٠,	f-re	Treat finger fracture, each	6.59	Ν	8.73	1.31	060	27049	٧	Remove tumor, hip/pelvis	15.20	ΝĀ	9,92	2.26	060
9.43 9.09 27052 A Biopsy of hip joint 7.27 NA 6.85 1.09 2.60 9.09 7.074 A Removal of hip joint liming 9.09 NA 7.84 1.15 3.40 9.09 2.0765 A Removal of hip joint liming 5.78 NA 7.64 0.87 3.48 9.09 2.0765 A Removal of hip bone lesion 6.44 NA 4.64 0.87 9.00 2.0765 A Removal of hip bone lesion 1.106 NA 9.03 1.66 1.23 9.09 2.0765 A Removal of hip bone lesion 1.144 NA 9.03 1.66 1.24 9.09 2.0765 A Removal of hip bone lesion 1.144 NA 9.03 1.66 1.25 9.09 2.0765 A Remove femine lesion lesion 1.144 NA 1.103 1.11 1.25 9.09 2.0775 A Remove femine lesion lesion 1.144 NA	9.43 9.09 2.7052 A Bopsy of hip joint 7.27 NA 6.85 1.09 2.64 9.09 2.7054 A Removed for hip joint liming 9.09 NA 7.84 1.04 0.79 2.60 9.09 2.7067 A Removed for lixing lunsa 5.78 NA 5.64 0.87 2.81 9.09 2.7065 A Removed for lixing bone lesion 6.44 NA 5.64 0.87 2.13 9.09 2.7065 A Removed for lixip bone lesion 1.106 NA 5.04 0.95 1.13 9.09 2.7065 A Removed for lixip bone lesion 1.144 NA 5.18 1.18 1.13 9.09 2.7066 A Removed for lixip bone lesion 1.144 NA 9.76 1.11 1.13 9.09 2.7076 A Removed for lixip bone lesion 1.144 NA 9.21 1.18 1.13 9.09 2.7077 A Retraisive li	: ∢		Freat finger fracture, each	1.74	2.71	2.72	0.24	060	27050	Ą	Biopsy of sacroiliac joint	4.65	٧Z	5.15	0.75	060
2.05 990 27054 A Removal of his joint lining 9.09 NA 7.84 1.36 2.06 990 27067 A Removal of his joint lining 5.78 NA 1.36 0.09 0.09 2.06 990 27062 A Remove from tesion bursa 5.64 NA 5.52 0.85 2.08 990 27066 A Removal of hip bone lesion 6.44 NA 5.03 0.85 1.25 990 27066 A Removal of hip bone lesion 11.45 NA 1.16 0.93 1.16 1.25 990 27070 A Remove from tesion 1.45 NA 1.16 0.93 1.18 1.15 990 27070 A Partial removal of thip bone 1.25 NA 1.26 1.18 1.15 990 27077 A Extensive hip surgery 4.254 NA 1.59 1.84 1.13 900 27077 A Extensiv	2.62 990 27054 A Removal of hitp joint lining 9.09 NA 7.84 1.36 2.60 990 27067 A Removal of hitp joint lining 5.78 NA 1.04 0.87 2.51 990 27062 A Removal of hitp bous lesion 5.78 NA 5.22 0.88 2.50 990 27066 A Removal of hitp bous lesion 11.06 NA 5.22 0.88 1.25 990 27067 A Removal of hitp bous lesion 11.47 NA 1.09 1.18 1.25 990 27067 A Removal of hitp bous lesion 11.47 NA 1.66 0.83 1.13 990 27071 A Removal of hitp bous lesion 11.47 NA 1.89 1.18 1.13 990 27071 A Remove light sugery 4.24 NA 1.90 1.89 1.89 1.89 1.89 1.89 1.89 1.89 1.89 1.89	: ∢	-	Treat finger fracture, each	3.15	4.47	3.54	0.43	060	27052	<	Biopsy of hip joint	7.27	NA	6.85	1.09	060
2.08 990 27067 A Buttock flasciotomy w/dbrdmt 14.77 NA 10.40 0.79 2.40 0.90 27062 A Removal of fsinab bursa 5.78 NA 4.64 0.83 2.08 27062 A Removal of hip bone lesion 6.44 NA 6.04 0.93 2.09 27065 A Removal of hip bone lesion 1.106 NA 9.09 1.103 1.18 1.13 0.90 27067 A Removal of hip bone lesion 1.44 NA 9.09 1.70 1.13 0.90 27067 A Removal of hip bone lesion 1.144 NA 9.06 1.71 1.13 0.90 27071 A Removal of hip bone lesion 1.144 NA 9.06 1.71 1.13 0.90 27071 A Removal of hip bone lesion 1.144 NA 9.06 1.71 1.13 2.00 Removal of hip bone lesion 1.144 NA 9.09 1.103<	2,80 990 27057 A Buttock fasciotomy w/dbrdmnt 1477 NA 1040 0.79 2,34 990 27062 A Removal of fishelb burse 5.78 NA 4,64 0.84 2,58 990 27062 A Removal of hip bone lesion 11.04 0.93 1.93 2,58 990 27066 A Removal of hip bone lesion 11.47 NA 4.04 0.93 1,15 990 27066 A Removal of hip bone lesion 11.44 NA 9.03 1.18 1,15 990 27073 A Removal of hip bone lesion 11.44 NA 9.03 1.18 1,15 990 27073 A Removal of hip bone lesion 11.44 NA 9.03 1.18 1,15 990 27073 A Retrial removal of hip bone lesion 11.44 NA 1.10 2.18 1,13 900 27073 A Retrial removal of hip bone lesion 11.44 <	. <	-	Pin finger fracture, each	4.46	NA	5.75	0.62	060	27054	<	Removal of hip joint lining	60'6	NA	7.84	1.36	060
940 27060 A Removal of ischial bursa 5.78 NA 4.64 0.87 5.3 990 27062 A Removal of iip bone lesion 6.44 NA 5.55 0.85 0.85 5.9 27065 A Removal of hip bone lesion 11.06 NA 5.93 1.66 1.2 990 27067 A Removal of hip bone lesion 11.06 NA 9.03 1.66 1.1.3 090 27070 A Removal of hip bone lesion 11.47 NA 9.03 1.18 1.1.5 090 27071 A Partial removal of hip bone lesion 11.47 NA 9.03 1.18 1.1.5 090 27071 A Partial removal of hip bone lesion 11.47 NA 9.03 1.84 1.1.5 090 27071 A Partial removal of hip bone lesion 11.47 NA 1.10 1.84 NA 1.10 1.84 NA 1.10 1.89 1.14 NA	3.40 9.90 27066 A Removal of ischial bursa 5.78 NA 4.64 0.87 5.31 9.90 27062 A Removal of his bone lesion 6.44 NA 5.52 0.83 5.90 27065 A Removal of his bone lesion 11.06 NA 9.03 1.06 5.90 27067 A Removal of his bone lesion 11.47 NA 9.13 1.16 1.31 990 27067 A Removal of his bone 11.47 NA 9.16 1.71 1.32 990 27071 A Partial removal of his bone 11.47 NA 9.06 1.71 9.90 27075 A Retaisive his surgery 4.45 NA 1.20 1.84 9.90 27075 A Extensive his surgery 4.45 NA 1.20 3.23 9.90 27078 A Extensive his surgery 4.45 NA 1.20 3.23 9.90 27079	. 4	. ,	Treat finger fracture, each	5.70	NA	6.56	0.80	060	27057	<	Buttock fasciotomy w/dbrdmt	14.77	NA	10.40	0.79	060
1.51 990 27062 A Remove fraur lesion bursa 5.66 NA 5.52 0.85 9.90 27066 A Removel of the bone lesion 11.06 NA 6.04 0.95 1.03 990 27066 A Removelgraft hip bone lesion 11.06 NA 9.16 1.96 1.13 990 27070 A Partial removal of hip bone 11.25 NA 9.18 9.18 1.13 990 27071 A Extensive hip surgery 24.25 NA 10.29 1.84 1.13 990 27075 A Extensive hip surgery 24.25 NA 10.29 1.84 1.13 990 27076 A Extensive hip surgery 24.25 NA 11.02 2.18 1.04 100 27077 A Extensive hip surgery 24.25 NA 11.02 2.18 1.05 200 27078 A Extensive hip surgery 14.54 NA 14.53	5.51 990 27062 A Remove femur lesion but loss 5.66 NA 5.22 0.85 208 990 27065 A Removel frain bone lesion 11.06 NA 6.44 NA 6.04 0.05 1.23 090 27065 A Removel graft hip bone lesion 11.04 NA 9.03 1.06 1.23 090 27070 A Removel graft hip bone lesion 11.44 NA 9.03 1.05 1.13 090 27070 A Retrait removal of hip bone 12.25 NA 9.03 9.03 1.13 090 27073 A Extensive hip surgery 42.45 NA 13.03 13.0 1.13 090 27075 A Extensive hip surgery 42.45 NA 14.34 NA 13.0 13.0 1.14 NA Extensive hip surgery 42.54 NA 14.34 NA 13.0 13.0 1.15 NA Extensive hip surgery </td <td><</td> <td>-</td> <td>Treat finger dislocation</td> <td>3.07</td> <td>3.58</td> <td>3.13</td> <td>0.40</td> <td>060</td> <td>27060</td> <td>٧</td> <td>Removal of ischial bursa</td> <td>5.78</td> <td>NA</td> <td>4,64</td> <td>0.87</td> <td>060</td>	<	-	Treat finger dislocation	3.07	3.58	3.13	0.40	060	27060	٧	Removal of ischial bursa	5.78	NA	4,64	0.87	060
909 27065 A Removal of hip bone lesion 6.44 NA 6.04 0.55 200 27066 A Removal of hip bone lesion 11.06 NA 9.03 1.66 1.03 27070 A Partial removal of hip bone 11.44 NA 9.76 1.71 1.33 090 27070 A Extensive hip surgery 12.25 NA 9.76 1.71 1.34 090 27075 A Extensive hip surgery 24.25 NA 1.64 3.63 1.66 1.34 090 27076 A Extensive hip surgery 24.25 NA 1.23 0.34 0.37 1.78 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 0.34 0.37 <td>508 990 27065 A Removal of hip bone ksion 644 NA 6.04 0.95 1.23 690 27066 A Removal of hip bone ksion 11.05 NA 9.03 1.103 1.18 1.23 690 27070 A Partial removal of hip bone ksion 11.44 NA 9.76 1.71 1.13 690 27071 A Extensive hip surgery 12.25 NA 9.76 1.71 1.34 600 27075 A Extensive hip surgery 42.25 NA 1.59 3.63 1.35 690 27078 A Extensive hip surgery 42.25 NA 1.59 3.63 1.30 1.30 A Extensive hip surgery 42.54 NA 1.10 2.23 2.31 EXZ A Extensive hip surgery 42.54 NA 1.10 2.23 2.32 2.70 A Extensive hip surgery 42.54 NA 1.10 2.23</td> <td><</td> <td>,</td> <td>Treat finger dislocation</td> <td>3.78</td> <td>5.51</td> <td>4.64</td> <td>0.51</td> <td>060</td> <td>27062</td> <td>٧</td> <td>Remove femur lesion/bursa</td> <td>99'5</td> <td>ΥZ</td> <td>5.52</td> <td>0.85</td> <td>060</td>	508 990 27065 A Removal of hip bone ksion 644 NA 6.04 0.95 1.23 690 27066 A Removal of hip bone ksion 11.05 NA 9.03 1.103 1.18 1.23 690 27070 A Partial removal of hip bone ksion 11.44 NA 9.76 1.71 1.13 690 27071 A Extensive hip surgery 12.25 NA 9.76 1.71 1.34 600 27075 A Extensive hip surgery 42.25 NA 1.59 3.63 1.35 690 27078 A Extensive hip surgery 42.25 NA 1.59 3.63 1.30 1.30 A Extensive hip surgery 42.54 NA 1.10 2.23 2.31 EXZ A Extensive hip surgery 42.54 NA 1.10 2.23 2.32 2.70 A Extensive hip surgery 42.54 NA 1.10 2.23	<	,	Treat finger dislocation	3.78	5.51	4.64	0.51	060	27062	٧	Remove femur lesion/bursa	99'5	ΥZ	5.52	0.85	060
9.90 27066 A Removal of hip bone lesion 11.06 NA 9.03 1.66 1.23 990 27070 A Remove/graft hip bone lesion 11.47 NA 9.03 1.66 1.25 990 27070 A Partial removal of hip bone 12.25 NA 9.06 1.84 1.15 990 27071 A Extensive hip surgery 36.77 NA 10.29 1.84 1.93 900 27077 A Extensive hip surgery 42.54 NA 10.29 1.84 1.04 900 27077 A Extensive hip surgery 42.54 NA 1.02 2.18 2.22 200 27078 A Extensive hip surgery 42.54 NA 1.02 2.18 2.33 2222 2222 27080 A Removal hip foreign body 1.89 4.14 1.76 0.19 2.34 500 27098 A Remova hip foreign body 1.89 4.24 <td>9.90 9.7066 A Removel of hip bone lesion 11.06 NA 9.03 1.66 1.23 990 27067 A Removel of hip bone lesion 11.47 NA 9.03 1.66 1.25 990 27071 A Partial removal of hip bone 11.25 NA 9.06 1.84 1.15 990 27071 A Extensive hip sugery 36.77 NA 10.29 1.84 1.15 990 27077 A Extensive hip sugery 42.54 NA 1.02 1.8 1.09 990 27077 A Extensive hip sugery 42.54 NA 1.02 1.8 1.09 1.20 A Extensive hip sugery 42.54 NA 1.02 2.18 2.09 2.7078 A Extensive hip sugery 42.54 NA 1.02 1.8 2.02 2.7078 A Extensive hip sugery 42.54 NA 1.10 1.8 2.22 2.708</td> <td><</td> <td>-</td> <td>Pin finger dislocation</td> <td>4.87</td> <td>ΝA</td> <td>5.92</td> <td>89.0</td> <td>060</td> <td>27065</td> <td>٧</td> <td>Removal of hip bone lesion</td> <td>6.44</td> <td>NA</td> <td>6.04</td> <td>0.95</td> <td>060</td>	9.90 9.7066 A Removel of hip bone lesion 11.06 NA 9.03 1.66 1.23 990 27067 A Removel of hip bone lesion 11.47 NA 9.03 1.66 1.25 990 27071 A Partial removal of hip bone 11.25 NA 9.06 1.84 1.15 990 27071 A Extensive hip sugery 36.77 NA 10.29 1.84 1.15 990 27077 A Extensive hip sugery 42.54 NA 1.02 1.8 1.09 990 27077 A Extensive hip sugery 42.54 NA 1.02 1.8 1.09 1.20 A Extensive hip sugery 42.54 NA 1.02 2.18 2.09 2.7078 A Extensive hip sugery 42.54 NA 1.02 1.8 2.02 2.7078 A Extensive hip sugery 42.54 NA 1.10 1.8 2.22 2.708	<	-	Pin finger dislocation	4.87	ΝA	5.92	89.0	060	27065	٧	Removal of hip bone lesion	6.44	NA	6.04	0.95	060
1.25 090 27067 A Remove/graft thip bone lesion 14.57 NA 11.03 2.18 1.35 090 27070 A Partial removal of thip bone 11.44 NA 9.70 1.34 1.15 090 27071 A Extensive hip surgery 26.77 NA 10.29 1.84 1.15 090 27077 A Extensive hip surgery 24.54 NA 15.09 3.67 1.09 090 27077 A Extensive hip surgery 4.54 NA 11.02 2.18 1.09 090 27078 A Extensive hip surgery 4.54 NA 11.02 2.18 1.09 27078 A Extensive hip surgery 4.54 NA 11.02 2.18 1.09 27079 A Extensive hip surgery 4.54 NA 11.02 2.18 2.00 27079 A Extensive hip surgery 4.54 NA 11.02 2.18 <t< td=""><td>1.25 090 27067 A Remove/graft hip bone kesion 14.57 NA 11.03 2.18 1.35 090 27070 A Partial removal of hip bone 11.44 NA 9.76 1.71 1.15 090 27071 A Extensive hip surgery 26.77 NA 10.29 1.84 1.15 090 27073 A Extensive hip surgery 26.77 NA 20.24 5.50 1.10 27073 A Extensive hip surgery 4.54 NA 11.02 2.18 1.09 27073 A Extensive hip surgery 4.54 NA 11.02 2.18 1.03 27079 A Extensive hip surgery 4.44 1.76 0.19 2.02 27079 A Extensive hip surgery 4.44 1.76 0.19 2.02 2709 A Retensive hip surgery 4.44 1.76 0.19 2.02 2709 A Remove hip foreign body 1.</td><td>¥</td><td>٠,</td><td>Treat finger dislocation</td><td>6,44</td><td>NA</td><td>6.95</td><td>06'0</td><td>060</td><td>27066</td><td><</td><td>Removal of hip bone lesion</td><td>11.06</td><td>ΝĄ</td><td>9.03</td><td>1.66</td><td>060</td></t<>	1.25 090 27067 A Remove/graft hip bone kesion 14.57 NA 11.03 2.18 1.35 090 27070 A Partial removal of hip bone 11.44 NA 9.76 1.71 1.15 090 27071 A Extensive hip surgery 26.77 NA 10.29 1.84 1.15 090 27073 A Extensive hip surgery 26.77 NA 20.24 5.50 1.10 27073 A Extensive hip surgery 4.54 NA 11.02 2.18 1.09 27073 A Extensive hip surgery 4.54 NA 11.02 2.18 1.03 27079 A Extensive hip surgery 4.44 1.76 0.19 2.02 27079 A Extensive hip surgery 4.44 1.76 0.19 2.02 2709 A Retensive hip surgery 4.44 1.76 0.19 2.02 2709 A Remove hip foreign body 1.	¥	٠,	Treat finger dislocation	6,44	NA	6.95	06'0	060	27066	<	Removal of hip bone lesion	11.06	ΝĄ	9.03	1.66	060
10.03 900 27070 A Partial removal of hip bone 11.44 NA 9.76 1.71 11.55 090 27075 A Extensive hip surgery 56.77 NA 10.24 5.09 1.33 090 27075 A Extensive hip surgery 24.25 NA 15.90 3.63 1.92 090 27077 A Extensive hip surgery 24.25 NA 15.90 3.63 1.03 090 27079 A Extensive hip surgery 45.44 NA 11.20 2.23 1.23 2722 27080 A Extensive hip surgery 4.51 NA 11.0 2.23 2.22 27080 A Extensive hip surgery 4.51 NA 1.10 2.23 2.22 27080 A Remove hip foreign body 8.72 NA 5.81 1.06 2.23 27090 A Remove hip foreign body 8.72 NA 6.98 1.72 2.8	1,03 900 27070 A Partial removal of bip bone 1144 NA 9.76 1.71 1,13 900 27071 A Partial removal of bip bone 11.25 NA 10.24 5.00 1,33 900 27075 A Extensive hip surgery 24.25 NA 15.90 3.63 1,92 090 27077 A Extensive hip surgery 42.54 NA 12.90 3.63 1,03 090 27079 A Extensive hip surgery 42.54 NA 12.90 3.63 1,03 2707 A Extensive hip surgery 42.54 NA 12.09 3.63 2,22 2708 A Extensive hip surgery 4.59 NA 1.20 2.23 2,22 2708 A Remove hip foreign body 8.72 NA 5.81 1.06 2,23 2708 A Remove hip foreign body 8.72 NA 6.38 1.37 2,22 2	⋖ (, ~	Thumb fusion with graft	8.33	NA	10.65	1.25	060	27067	<	Remove/graft hip bone lesion	14.57	ΝA	11.03	2.18	060
1.2.5 0.90 27071 A Partial removal of tip bone 12.25 NA 10.29 1.84 1.1.3 0.90 27075 A Extensive hip surgery 36.77 NA 20.24 5.50 5.92 0.90 27076 A Extensive hip surgery 42.54 NA 24.33 6.37 5.92 0.90 27077 A Extensive hip surgery 42.54 NA 24.33 6.37 5.22 0.90 27078 A Extensive hip surgery 14.54 NA 11.00 22.18 5.22 27080 A Remove thip surgery 14.91 NA 1.81 1.05 2.23 5.22 27080 A Remove thip foreign body 1.87 NA 5.81 1.06 5.83 0.90 27096 A Remove thip foreign body 1.14 1.76 0.19 5.83 0.92 27090 A Removal of tap foreign body 8.72 NA 6.92 1.72 </td <td>1.2.5 0.90 27071 A Retain removal of tip bone 12.25 NA 10.29 1.84 1.15 0.90 27075 A Extensive hip surgery 36.77 NA 15.90 3.63 9.92 27077 A Extensive hip surgery 42.54 NA 15.90 3.63 2.32 2.22 27078 A Extensive hip surgery 42.54 NA 12.53 6.37 2.33 2.22 2.7078 A Extensive hip surgery 42.54 NA 12.02 2.18 2.34 2.22 2.708 A Removal of pusugery 4.44 NA 1.10 2.18 3.88 2.22 2.708 A Removal of pusugery 1.89 4.14 1.76 0.19 3.88 2.22 2.708 A Removal of pusugery 8.80 NA 1.89 1.14 1.76 0.19 3.83 2.22 2.708 A Removal of pusugery 1.89 4.1</td> <td>∢</td> <td>_</td> <td>Fusion of thumb</td> <td>7.21</td> <td>NA</td> <td>10.38</td> <td>1.03</td> <td>060</td> <td>27070</td> <td>4</td> <td>Partial removal of hip bone</td> <td>11.44</td> <td>ΥZ</td> <td>9.76</td> <td>1.71</td> <td>060</td>	1.2.5 0.90 27071 A Retain removal of tip bone 12.25 NA 10.29 1.84 1.15 0.90 27075 A Extensive hip surgery 36.77 NA 15.90 3.63 9.92 27077 A Extensive hip surgery 42.54 NA 15.90 3.63 2.32 2.22 27078 A Extensive hip surgery 42.54 NA 12.53 6.37 2.33 2.22 2.7078 A Extensive hip surgery 42.54 NA 12.02 2.18 2.34 2.22 2.708 A Removal of pusugery 4.44 NA 1.10 2.18 3.88 2.22 2.708 A Removal of pusugery 1.89 4.14 1.76 0.19 3.88 2.22 2.708 A Removal of pusugery 8.80 NA 1.89 1.14 1.76 0.19 3.83 2.22 2.708 A Removal of pusugery 1.89 4.1	∢	_	Fusion of thumb	7.21	NA	10.38	1.03	060	27070	4	Partial removal of hip bone	11.44	ΥZ	9.76	1.71	060
115 090 27075 A Extensive hip surgery 36.77 NA 20.24 55.0 1.30	11.15 090 27075 A Extensive hip surgery 36.77 NA 20.24 5.50 1.32 090 27076 A Extensive hip surgery 4.25 NA 15.90 3.63 1.09 090 27077 A Extensive hip surgery 4.54 NA 11.02 2.18 1.05 090 27078 A Extensive hip surgery 4.54 NA 11.02 2.18 2.32 22Z 27080 A Extensive hip surgery 4.14 1.02 2.18 2.88 1090 27086 A Removal of hip prosthess 4.14 1.76 0.19 2.88 22Z 27080 A Removal of hip prosthesis 1.87 NA 5.08 1.29 2.11 000 27091 A Removal of hip prosthesis 1.15 NA 5.36 0.11 2.89 090 27091 A Removal of hip prosthesis 1.15 NA 1.58 3.61	<	4	Thumb fusion with graft	8.37	NA	10.67	1.25	060	27071	<	Partial removal of hip bone	12.25	Ϋ́Z	10.29	1.84	060
1.33 990 27076 A Extensive hip surgery 24.25 NA 15.90 36.3 9.90 27077 A Extensive hip surgery 42.54 NA 14.59 3.63 5.63 900 27079 A Extensive hip surgery 14.91 NA 11.20 2.23 2.23 222 27080 A Removal of fail bone 6.80 NA 5.81 1.06 2.23 2.88 2.22 27080 A Removal of fail bone 6.80 NA 5.81 1.06 0.19 2.88 2.22 27080 A Removal of fail bone 6.80 NA 5.81 1.06 0.19 2.88 1.24 A Removal of fail bone 6.80 NA 5.81 1.06 0.11 2.88 1.24 NA Removal of hip prosithesis 11.57 NA 6.98 1.72 2.83 9.0 2.7093 A Injection for hip x-ray 1.50 3.46 <td>133 990 27076 A Extensive hip surgery 24.25 NA 15.90 36.3 10.90 900 27077 A Extensive hip surgery 42.54 NA 14.53 6.37 10.90 900 27079 A Extensive hip surgery 14.91 NA 11.20 2.23 2.22 2.22 27080 A Remove hip foreign body 8.72 NA 5.81 1.06 5.8 2.22 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 5.8 2.22 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 090 27091 A Remove hip foreign body 8.72 NA 6.98 1.29 2.02 27092 A Remove hip foreign body 8.72 NA 6.98 1.29 2.03 27091 A Remove hip foreign body 8.72 NA 1.36 1.29 1.</td> <td>ď</td> <td></td> <td>Fusion of hand joint</td> <td>7.67</td> <td>NA</td> <td>10.11</td> <td>1.15</td> <td>060</td> <td>27075</td> <td>¥</td> <td>Extensive hip surgery</td> <td>36.77</td> <td>Ϋ́Z</td> <td>20.24</td> <td>5.50</td> <td>060</td>	133 990 27076 A Extensive hip surgery 24.25 NA 15.90 36.3 10.90 900 27077 A Extensive hip surgery 42.54 NA 14.53 6.37 10.90 900 27079 A Extensive hip surgery 14.91 NA 11.20 2.23 2.22 2.22 27080 A Remove hip foreign body 8.72 NA 5.81 1.06 5.8 2.22 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 5.8 2.22 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 090 27091 A Remove hip foreign body 8.72 NA 6.98 1.29 2.02 27092 A Remove hip foreign body 8.72 NA 6.98 1.29 2.03 27091 A Remove hip foreign body 8.72 NA 1.36 1.29 1.	ď		Fusion of hand joint	7.67	NA	10.11	1.15	060	27075	¥	Extensive hip surgery	36.77	Ϋ́Z	20.24	5.50	060
992 090 27077 A Extensive hip surgery 42.54 NA 24.53 637 633 090 27078 A Extensive hip surgery 14.54 NA 11.02 2.23 5.22 27079 A Removal of tail bone 6.80 NA 5.81 1.06 5.83 222 27086 A Removal of tail bone 6.80 NA 5.81 1.06 5.84 0.90 27086 A Remove hip foreign body 8.72 NA 5.81 1.06 5.83 0.90 27090 A Removal of hip prosthesis 11.57 NA 6.98 1.72 5.83 0.90 27091 A Removal of hip prosthesis 24.15 NA 5.86 0.01 5.00 77093 A Injection for hip x-ray 1.30 4.32 0.64 0.14 5.18 0.90 27095 A Injection for hip x-ray 1.30 4.32 0.64 0.14	992 090 27077 A Extensive hip surgery 42.54 NA 24.53 6.37 10.63 090 27078 A Extensive hip surgery 14.54 NA 11.20 2.218 10.23 22.22 27080 A Remove hip foreign body 1.89 4.14 1.76 0.19 1.14 090 27080 A Remove hip foreign body 8.72 NA 5.81 1.06 1.18 090 27090 A Remove hip foreign body 8.72 NA 6.89 1.79 0.19 1.11 090 27091 A Remove hip foreign body 8.72 NA 6.98 1.20 1.11 090 27091 A Remove hip foreign body 8.72 NA 6.93 1.17 1.18 090 27091 A Remove hip foreign body 8.72 NA 1.58 3.61 1.80 40 27093 A Remove hip foreign body 8.715 <t< td=""><td>×</td><td></td><td>Fusion/graft of hand joint</td><td>8.86</td><td>NA</td><td>10.91</td><td>1.33</td><td>060</td><td>27076</td><td>¥</td><td>Extensive hip surgery</td><td>24.25</td><td>NA</td><td>15.90</td><td>3.63</td><td>060</td></t<>	×		Fusion/graft of hand joint	8.86	NA	10.91	1.33	060	27076	¥	Extensive hip surgery	24.25	NA	15.90	3.63	060
(10) (10) (10) (11) <th< td=""><td>(10) (10) (10) (11) <t< td=""><td>¥</td><td>_</td><td>Fusion of knuckle</td><td>7.03</td><td>NA</td><td>08'6</td><td>0.92</td><td>060</td><td>27077</td><td>٧</td><td>Extensive hip surgery</td><td>42.54</td><td>ΝĄ</td><td>24.53</td><td>6.37</td><td>060</td></t<></td></th<>	(10) (10) (10) (11) <t< td=""><td>¥</td><td>_</td><td>Fusion of knuckle</td><td>7.03</td><td>NA</td><td>08'6</td><td>0.92</td><td>060</td><td>27077</td><td>٧</td><td>Extensive hip surgery</td><td>42.54</td><td>ΝĄ</td><td>24.53</td><td>6.37</td><td>060</td></t<>	¥	_	Fusion of knuckle	7.03	NA	08'6	0.92	060	27077	٧	Extensive hip surgery	42.54	ΝĄ	24.53	6.37	060
5.63 900 27079 A Extensive hip surgery 14.91 NA 11.20 2.23 5.22 27080 A Removal of fail bone 6.80 NA 5.81 1.06 5.8 222 27087 A Removal of fail postign body 8.72 NA 6.98 1.29 5.8 222 27087 A Removal of hip prosthesis 11.57 NA 6.98 1.29 5.8 27090 A Removal of hip prosthesis 11.57 NA 1.58 3.61 5.8 500 27093 A Injection for hip x-ray 1.30 3.46 0.55 0.14 5.0 77095 A Injection for hip x-ray 1.30 3.46 0.55 0.14 5.0 77095 A Injection for hip x-ray 1.30 3.46 0.55 0.14 5.0 77095 A Injection for hip x-ray 1.50 NA 3.88 1.34 6.0 77096 <t< td=""><td>163 909 27079 A Extensive hip surgery 14.91 NA 11.20 22.3 232 2222 27086 A Remove hip foreign body 1.89 4.14 1.76 0.19 5.8 222 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 990 27081 A Remove hip foreign body 8.72 NA 6.98 1.29 1.13 900 27091 A Removal of hip prosthesis 1.15 NA 6.98 1.29 2.89 900 27091 A Removal of hip prosthesis 1.13 3.46 0.55 0.11 2.89 1.20 A Removal of hip prosthesis 1.13 3.46 0.55 0.11 2.00 YYY 27095 A Inject socoliac joint 1.40 3.49 0.55 0.01 2.02 Oy 27095 A Transfer tendon to pelvis 9.20 NA 7.65</td><td>-</td><td>_</td><td>Fusion of knuckle with graft</td><td>8.59</td><td>NA</td><td>10.83</td><td>1.09</td><td>060</td><td>27078</td><td>Ą</td><td>Extensive hip surgery</td><td>14.54</td><td>AN</td><td>11.02</td><td>2.18</td><td>060</td></t<>	163 909 27079 A Extensive hip surgery 14.91 NA 11.20 22.3 232 2222 27086 A Remove hip foreign body 1.89 4.14 1.76 0.19 5.8 222 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 990 27081 A Remove hip foreign body 8.72 NA 6.98 1.29 1.13 900 27091 A Removal of hip prosthesis 1.15 NA 6.98 1.29 2.89 900 27091 A Removal of hip prosthesis 1.13 3.46 0.55 0.11 2.89 1.20 A Removal of hip prosthesis 1.13 3.46 0.55 0.11 2.00 YYY 27095 A Inject socoliac joint 1.40 3.49 0.55 0.01 2.02 Oy 27095 A Transfer tendon to pelvis 9.20 NA 7.65	-	_	Fusion of knuckle with graft	8.59	NA	10.83	1.09	060	27078	Ą	Extensive hip surgery	14.54	AN	11.02	2.18	060
9.22 27086 A Removal of tail bone 6.80 NA 5.81 1.06 9.98 27086 A Removal of tail bone 1.89 4.14 1.76 0.19 1.11 202 27087 A Removal of this prosthesis 8.72 NA 6.98 1.29 1.11 200 27090 A Removal of this prosthesis 24.15 NA 6.98 1.29 3.83 090 27091 A Ripection for hip x-ray 1.30 3.46 0.52 0.11 2.00 1.70 A Injection for hip x-ray 1.50 4.32 0.64 0.14 2.18 0.90 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 2.18 0.90 27096 A Injection for hip x-ray 1.50 NA 5.88 1.38 2.02 1.03 A Inject sacrolliac joint 1.40 3.49 0.55 0.09 2.03	923 2222 27086 A Removal of fail bone 6.80 NA 5.81 1.06 9.88 9.90 27086 A Removal of fail prostlessis 1.137 NA 5.98 1.29 1.11 900 27090 A Removal of fail prostlessis 11.57 NA 6.98 1.20 1.83 909 27091 A Removal of fail prostlessis 24.15 NA 1.86 3.61 2.00 YY 27093 A Injection for hip x-ray 1.30 4.32 0.64 0.14 1.18 900 27095 A Injection for hip x-ray 1.30 4.32 0.64 0.14 1.18 900 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.18 900 27096 A Injection for hip x-ray 1.50 4.32 0.64 0.14 2.02 1.03 A Injection for hip x-ray 1.50 A.32 0.64 <td></td> <td>_</td> <td>Fusion of finger joint</td> <td>4.76</td> <td>NA</td> <td>8.80</td> <td>0.63</td> <td>060</td> <td>27079</td> <td>٧</td> <td>Extensive hip surgery</td> <td>14.91</td> <td>NA</td> <td>11.20</td> <td>2.23</td> <td>060</td>		_	Fusion of finger joint	4.76	NA	8.80	0.63	060	27079	٧	Extensive hip surgery	14.91	NA	11.20	2.23	060
9.98 9.99 27086 A Remove hip foreign body 1.89 4.14 1.76 0.19 5.38 2222 27090 A Remove hip foreign body 8.72 NA 6.19 5.83 900 27090 A Removal of hip prosthesis 1.157 NA 6.02 1.72 5.89 900 27091 A Removal of hip prosthesis 24.15 NA 15.86 3.61 5.89 900 27091 A Injection for hip x-ray 1.30 3.42 0.55 0.11 5.00 YYY 27095 A Injection for hip x-ray 1.50 4.22 0.64 0.14 5.01 YYY 27095 A Inject sacroliac discontaine joint 1.40 3.49 0.55 0.01 5.02 77095 A Transfer tendon to pelvis 9.16 NA 5.8 1.37 5.02 900 27097 A Transfer tendon to pelvis 9.16 NA 5.8 <t< td=""><td>9.98 9.09 27086 A Remove hip foreign body 1.89 4.14 1.76 0.19 5.38 22.22 27087 A Remove hip foreign body 8.75 NA 6.19 5.38 200 27091 A Removal of hip prosthesis 1.157 NA 6.02 1.29 5.89 090 27091 A Removal of hip prosthesis 24.15 NA 15.86 3.61 5.00 27093 A Injection for hip x-ray 1.30 43.45 0.55 0.01 1.18 090 27095 A Injection for hip x-ray 1.30 43.49 0.55 0.01 1.05 090 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 2.02 1.90 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 2.02 1.27 A A Transfer tendon to petvis 9.20 NA 7.65 1.37</td><td>-</td><td>-</td><td>Fusion of finger int. add-on</td><td>1.74</td><td>ΝA</td><td>16'0</td><td>0.23</td><td>277</td><td>27080</td><td>٧</td><td>Removal of tail bone</td><td>6.80</td><td>ΥN</td><td>5.81</td><td>90.1</td><td>060</td></t<>	9.98 9.09 27086 A Remove hip foreign body 1.89 4.14 1.76 0.19 5.38 22.22 27087 A Remove hip foreign body 8.75 NA 6.19 5.38 200 27091 A Removal of hip prosthesis 1.157 NA 6.02 1.29 5.89 090 27091 A Removal of hip prosthesis 24.15 NA 15.86 3.61 5.00 27093 A Injection for hip x-ray 1.30 43.45 0.55 0.01 1.18 090 27095 A Injection for hip x-ray 1.30 43.49 0.55 0.01 1.05 090 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 2.02 1.90 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 2.02 1.27 A A Transfer tendon to petvis 9.20 NA 7.65 1.37	-	-	Fusion of finger int. add-on	1.74	ΝA	16'0	0.23	277	27080	٧	Removal of tail bone	6.80	ΥN	5.81	90.1	060
5.58 ZZZZ 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 090 27090 A Removal of hip prosthesis 1.15 NA 1.59 1.72 38.9 090 27093 A Injection for hip x-ray 1.30 3.46 0.55 0.11 5.00 YYY 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 5.00 YYY 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 5.02 A Injection for hip x-ray 1.50 4.32 0.64 0.14 5.03 A Injection for hip x-ray 1.50 4.32 0.64 0.14 5.04 A Injection for hip x-ray 1.50 4.32 0.64 0.14 5.05 A Injection for hip x-ray 1.50 A 1.38 1.34 6.0 A Injection for hip x-ray 1.50 NA<	5.58 ZZZZ 27087 A Remove hip foreign body 8.72 NA 6.98 1.29 1.11 090 27091 A Removal of hip prosthesis 1.15 NA 5.98 1.29 3.83 090 27091 A Removal of hip prosthesis 1.15 NA 1.56 3.17 5.89 0.00 27093 A Injection for hip x-ray 1.30 4.35 0.61 0.11 5.00 YYY 27095 A Injection for hip x-ray 1.50 4.39 0.55 0.01 1.18 0.90 27095 A Inject sacroliac joint 1.40 3.49 0.55 0.01 2.02 0.90 27097 A Revision of hip tendon 9.16 NA 5.88 1.38 2.02 1.20 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.02 1.20 A Transfer tendon to pelvis 9.20 NA 5.88 1.38	- ₹	-	Fusion/graft of finger joint	7.44	NA	10.26	0.98	060	27086	¥	Remove hip foreign body	1.89	4.14	1.76	61.0	010
11 090 27090 A Removal of hip prosthesis 11.57 NA 9.02 1.72 12	1.11 0.90 27090 A Removal of hip prosthesis 11.57 NA 9.02 1.72 1.23 0.90 27091 A Removal of hip prosthesis 24.15 NA 15.86 3.61 1.30 27092 A Injection for hip x-ray 1.30 3.46 0.14 1.30 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.30 0.90 27096 A Inject sacrolliac joint 1.40 3.49 0.55 0.19 1.30 0.90 27098 A Inject sacrolliac joint 1.40 3.49 0.55 0.19 1.30 0.90 27098 A Inject sacrolliac joint 1.40 3.49 0.55 0.19 1.31 0.90 27098 A Inject sacrolliac joint 1.40 3.49 0.55 0.19 1.32 0.90 27098 A Inject sacrolliac joint 1.40 3.49 0.55 0.19 1.33 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights 1.32 0.90 27098 CPT codes and descriptions only are copyright 2009 American Medical shave been catallated as a courtesty to the general public and are not used for Medicare payment. 2	*	,	Fuse/graft added joint	3.89	NA	16.1	0.58	ZZZ	27087	Ą	Remove hip foreign body	8.72	ΝΑ	86'9	1.29	060
1990 27091	983 990 27091 A Removal of hip prosthesis 24.15 NA 15.86 361 289 900 27095 A Injection for hip x-ray 1.30 4.32 0.64 0.14 1.18 900 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.18 900 27096 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.05 900 27096 A Inject sacroliac joint 1.40 3.49 0.55 0.09 2.02 A Inject sacroliac joint 9.16 NA 7.65 0.09 2.09 27097 A Transfer tendon to pelvis 9.20 NA 5.8 1.38 Reserved. - 1 Transfer tendon to pelvis 9.0 NA 5.88 1.38 Reserved. - 2 Trougs and descriptions only are copyright 2009 American Medical these values have been catalathese values are released for Medicare, place one that these values have been catalathese values have been catalathese values	¥	٠,	Amputate metacarpal bone	7.67	NA	9.74	1:1	060	27090	٧	Removal of hip prosthesis	11.57	ΥN	9.02	1.72	060
27093 A injection for hip x-ray 1.30 3.46 0.55 0.11 27095 A injection for hip x-ray 1.30 4.32 0.64 0.14 27096 A inject sacrollac joint 1.50 4.32 0.64 0.14 27097 A Revision of thip tendon 9.16 3.49 0.55 0.09 27097 A Revision of thip tendon 9.16 3.49 0.55 0.09 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 27098 A Transfer tendon to pelvis 9.20 NA 5.80 1.37 2.02 0.90 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.03 Reserved. Reserved. 1.20 1.20 2.04 Redicate san enflected for codes not payable by Medicare, please note that these values have been established as a courtesty to the general public and are not used for Medicare payment. 1.20 1.20 2.05 Redicate payment. 1.20 1.20 1.20 3.06 1.20 1.20 1.20 1.20 4.25 1.20 1.20 1.20 5.06 1.20 1.20 1.20 6.07 1.20 1.20 1.20 6.08 1.20 1.20 1.20 7.08 1.20 1.20 1.20 8.08 1.20 1.20 9.08 1.20 1.20 9.09 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 1.20 9.00 1.20 9.00 1.20 1.20 9.00 1.20 9.00 1.20 1.20 9.00 1.20	130 346 0.55 0.11 27093	4	4	Amputation of finger/thumb	5.85	NA	9.83	0.83	060	27091	<	Removal of hip prosthesis	24.15	ΝA	15.86	3.61	060
1.50 YYY 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.80 0.90 27096 A Injection for hip x-ray 1.50 4.32 0.65 0.014 1.80 0.90 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 2.02 0.90 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.03 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.04 2.05 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.05 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.05 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.05 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 3.099 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 3.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 3.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 3.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 4.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 5.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 5.090 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 5.090 A Transfer tendon t	1.50 YYY 27095 A Injection for hip x-ray 1.50 4.32 0.64 0.14 1.80 0.90 27096 A Injection for hip x-ray 1.50 4.32 0.65 0.09 1.80 0.90 27097 A Revision of hip tendon 9.10 NA 7.65 1.37 2.02 0.90 27097 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.03 0.90 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.04 0.90 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.05 0.90 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 2.06 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 3.07 1.80 1.80 1.80 4.07 1.80 1.80 1.80 5.06 1.80 1.80 1.80 6.06 1.80 1.80 1.80 7.06 1.80 1.80 1.80 8.06 1.80 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 9.00 1.80 1.80 1.80 1	~	4	Amputation of finger/thumb	6.37	¥V.	9.26	68.0	060	27093	4	Injection for hip x-ray	1.30	3,46	0.55	0.11	000
1.8 0.90 27096	1.8 0.90 27096	Ö		Hand/finger surgery	0.00	00:0	0.00	0.00	YYY	27095	٧	Injection for hip x-ray	1.50	4.32	0.64	0.14	000
1.05 0.90 2.7097	1.05 090 27097 A Revision of hip tendon 9.16 NA 7.65 1.37 1.20 2.02 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 1.38 1.38 1.39 1.20 2.00 NA 5.80 1.30 NA 5.80 N	<		Orainage of pelvis lesion	7.84	NA	7.47	1.18	060	27096	4	Inject sacroiliac joint	1.40	3.49	0.55	60.0	000
2.02 090 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 'CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Reserved. 1 fr values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.	2.02 090 27098 A Transfer tendon to pelvis 9.20 NA 5.88 1.38 1.38 'CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 1 frailuses are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the files used for Medicare payment. Codes 98940, 9894, and 98942. The required reduction will only be reflected in the files used for Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.	٧	Н	Drainage of pelvis bursa	6.97	10.32	86.5	1.05	060	27097	٧	Revision of hip tendon	9.16	ΥZ	7.65	1.37	060
for CPT	for CPT	4	_	Drainage of bone lesion	13.37	NA	10.45	2.02	060	27098	٧	Transfer tendon to pelvis	9.20	NA	5.88	1.38	060
for CPT	for CPT	and	સ	scriptions only are copyright 2009.	American Med	ical Associa	tion. All Ri	thts		' CPT cod	les and	descriptions only are copyright 2009 /	American Med	tical Associa	tion. All Rig	ıts	
for CPT	for CPT				-		-			Reserved				100	4 L		
for CPT	for CPT	re ret	დ მ	cred for codes not payable by Media	care, piease no	te mat mese Peticare navn	values nave	Deen		ii vaues establishe	dasac	rected for codes not payable by intenc-	are, picase uo ot used for M	edicare payir	values have u	13	
		t neul	3 2	lity reduction from the charpractic	demonstration	is not reflec	ted in the R	VUs for CPT		³ The bud	get neul	trality reduction from the chiropractic	demonstration	n is not reflec	ted in the RV	Us for CPT	
	nalpractice RVUs may not sum due to rounding.	, 989	Ŧ	1, and 98942. The required reductiv	a will only be	reflected in	the files use	l for		codes 989	40,989	41, and 98942. The required reduction	n will only be	reflected in	the files used	for	
		Medicare payment.								Medicare	paymer	; ;;	;				

^{*}If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 19840, 49841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malgractice RVUs may not sum due to rounding.

Global	060	060	060	060	060	060	060	060	060	060	000	060	060	060	010	010	Geo	060	000	000	260	260	060	0.00	060	060	060	060	060	060	YYY	060	060	060	060	060	060	010	060	060	060	060								
Mal- Practice RVUs ^{2,3,4}	0.84	1.71	1.92	2.60	0.84	2.02	2.68	2.68	0.70	1.59	0.39	1.60	2.01	2.81	0.45	0.64	2.40	3.45	040	60.0	± -0 0	10.0	27.6	92.0	224	1.75	3.73	3.74	3.65	3.04	0.00	1.02	1.27	0.92	0.70	68'0	1.47	0.27	0.77	1.06	96.0	0.70	ghts		peen	VI le for CPT	to see	į		
Facility PE RVUs ^{2,3}	5.88	7.38	89.6	12.38	5.64	10.13	12.66	12.68	4.74	7.81	0.82	7.91	9.95	12.76	1.74	2 96	11 53	15.59	3.54	4.33	0.00	0.40	0.20	200	11.02	9.40	15.56	16.24	16.14	11,90	0.00	5.65	7.29	2.67	4.93	5.79	8.21	2.17	4.60	6.57	6.21	4.35	tion. All Rig		values have	red in the P	the files used			
Non- Facility PE RVUs.3	5.96	Y Y	Ν	Ϋ́Α	ΥZ.	ΝA	۷Z	ΑN	4.70	ΝA	AN	NA	ΥX	NA	2.96	AZ.	. 2	V V	(×	ć <u> </u>	¥ × ×	ζ., ,	ζ <u>γ</u>	(V	NA NA	NA	NA	NA	NA	Ϋ́	0.00	17.6	NA	NA	NA	NA	NA	4.45	Y.	NA	NA	7.08	lical Associa		te that these	culcate payu is not reflec	reflected in			
Physician cian Work	5.69	11.66	12.88	17.43	5.64	13.66	18.00	18.00	4.75	10.64	3.82	10.92	13.46	18.80	4.25	5 3 5	16.04	73.03	5.13	2.12	10.7	2.38	30.7	2,30	14.49	11.71	24.91	24.97	24.38	19,54	00.0	19.9	8.52	60.9	4.66	5.97	88.6	2.30	4.95	7.09	6.36	4.52	9 American Mec		licare, please no	ic demonstration	ic demonstration fon will only be	/	te to rounding.	; !
Dascrittion	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat thigh fracture	Treat hip dislocation	Treat hip dislocation	Treat bip dislocation	Treat hip dislocation	Treat hin dislocation	Treat hin dislocation	Treat him dislocation	Treat his dislocation	Treat hip dislocation	Treet hip dislocation	Treat hip distocation		Cux unign ix w/mmpj	Opta targat ta Manipulation of his loint	Fusion of sacrolliac joint	Fusion of pubic bones	Fusion of hip joint	Fusion of hip joint	Amputation of leg at hip	Amputation of leg at hip	Pelvis/hip joint surgery	Drain thigh/knee lesion	Drainage of bone lesion	Incise thigh tendon & fascia	Incision of thigh tendon	Incision of thigh tendons	Exploration of knee joint	Biopsy, thigh soft tissues	Biopsy, thigh soft tissues	Neurectomy, hamstring	Neurectomy, popliteal	Removal of thigh lesion	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	established as a countest to the general public and are not used to litterinale payment. The hiddest sampolity radiotion from the chirometric damonetration is not reflected in the PVI is for CPT.	i de budget neutraniy reduction nom me embopractic demonstration is not renected in me is you observed. See the	II.	Global totals for malpractice RVUs may not sum due to rounding.	,
sutes.	4	¥	Ą	¥	¥	Ą	¥	¥	¥	٧	K	<	₹	V	<	: ∢	; ⊲	۲ -	< <	< <	< <	₹ •	€ <	< <	. ≺	<	<	¥	¥.	Ą	ပ	V	¥	٧	¥	¥	<	∢	ď	٧	4	¥	codes and	ed.	ues are refl	sucu as a cu	noget neur 38940, 989	Medicare payment.	il totals for	
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CPT ⁽³⁾	27230	27232	27235	27236	27238	27240	27244	27245	27246	27248	27250	27252	27253	27254	9577	77757	37758	27750	37020	23277	007/7	19717	27750	27775	27280	27282	27284	27286	27290	27295	27299	27301	27303	27305	27306	27307	27310	27323	27324	27325	27326	27327								
86 Slobal																									060												060			_	060	_				CPT	-			
Mai- Practice PVII=23.4 Global																									060 (67												1.12 090		2.05 090	_		4.36 090	Zights		e been	PV/Tie for CPT	RVOS 301 CF1			
_+	89.1	1.78	2.04	1.87	2.86	2.37	2.46	3.23		4.50	3.37	3.52	061		3.27		90.5		5.13	5.04	66.7	7.07	6.1	1.9.1		2.07		0.52	2.11	68'0	1.21	0.26	1.09		0.84	0.78	1.12	00.1		2.31	3.77	_	ation. All Rights		e values have been	incin.	acted in the KVOS for Cr 1			
Mal- Practice	9,16 1.68	9.50 1.78	10.35 2.04	72.1 77.6	13.24 2.86	2.37	2.46	3.23	3.81	4.50	14,44 3.37	14.93 3.52	061	13.17 2.80	14.77 3.27	15.73 3.58	15.77	14.04 3.30	51.5 +0.41	14.14 2.04	66.7	11.93 2.61	1.25	1.9.1	9.93	10.35 2.07	11.82 2.39	5.70 0.52	10.55 2.11	5.73 0.89	7.14 1.21	2.69 0.26	5.93 1.09	0.56	8.00 0.84	7.60 0.78	9.89 1.12	6.22 1.00	2.05	2.31	3.77	4.36	dical Association. All Rights		ote that these values have been	rearcare payment.	n is not reducted in the K v OS Jur Cr i reflected in the files used for			
Facility Mal- PE Practice PVIIs ²³ PVIIs ^{23,4} C	NA 9,16 1.68	NA 9.50 1.78	10.35 2.04	72.1 77.6	13.24 2.86	NA 11.47 2.37	2.46	3.23	NA 16.53 3.81	NA 18.16 4.50	NA 14,44 3.37	NA 14.93 3.52	061 656 VN	NA 13.17 2.80	NA 1477 327	NA 1573 358	NA 15.77 3.00	14.04 3.30	51.5 +0.41 AN	14.14 2.04	NA 14.14 2.99	NA 11.93 2.61	1.25	16.1 5.5.5 AM	NA 9.93 1.91	NA 10.35 2.07	NA 11.82 2.39	NA 5.70 0.52	NA 10.55 2.11	5.57 5.73 0.89	NA 7.14 1.21	2.52 2.69 0.26	NA 5.93 1.09	NA 5.53 0.56	8.00 0.84	NA 7.60 0.78	NA 9.89 1.12	6.33 6.22 1.00	10.22 2.05	10.95 2.31	3.77	18.27 4.36	American Medical Association. All Rights		care, please note that these values have been	not used for Medicare payment.	emonstration is not reflected in the files used for		to rounding.	,
Non- Facility Mather Performance PE PE Practice PE PE Practice Performance Per	Transfer of abdominal muscle 11.21 NA 9.16 1.68	NA 9.50 1.78	NA 10.35 2.04	12.46 NA 9.77 1.87	Reconstruction of hip socket 19.10 NA 13.24 2.86	Reconstruction of hip socket 15.95 NA 11.47 2.37	Partial hip replacement 16.46 NA 11.72 2.46	21.61 NA 14.46 3.23	Total hip arthroplasty 25.49 NA 16.53 3.81	Revise hip joint replacement 30.13 NA 18.16 4.50	Revise hip joint replacement 22.55 NA 14.44 3.37	Revise hip joint replacement 23.55 NA 14.93 3.52	Transmiant femur ridge 12.66 NA 9.59 1.90	18.72 NA 13.17 2.80	Pevision of hin hone 21.87 NA 14.72 3.27	Indicion of his bone 73.07 NA 15.73 3.88	Description of this Leaves 26.03 NA 16.77 3.00	Revision of nip bones 20.03 INA 10.17 3.90	Kevision of peivis	Inclision of neck of female 17.74 1974 12.31 2.04	incision/tixation of femuration of femuratio	Repair/graft temur head/neck 17.46 NA 11.93 2.01	reat Supped epiphysis 9.29 NA 7.22 1.39	Tent supped epipolosis 12.10 (A) 11.20 2.20	NA 993 1.91	Revise head/neck of femure 13.83 NA 10.35 2.07	Treat slinned eninhysis 15 98 NA 11.82 2.39	Revision of femure piphysis 9.67 NA 5.70 0.52	Reinforce hip bones 14.09 NA 10.55 2.11	Treat pelvic ring fracture 5.98 5.57 5.73 0.89	Treat pelvic ring fracture 10.08 NA 7.14 1.21	Treat tail bone fracture 1.87 2.52 2.69 0.26	NA 5.93 1.09	10.45 NA 5.53 0.56	NA 8.00 0.84	NA 7.60 0.78	: 20.93 NA 9.89 1.12	6.33 6.22 1.00	re 13.97 NA 10.22 2.05	NA 10.95 2.31	25.21 NA 16.34 3.77	NA 18.27 4.36	codes and descriptions only are copyright 2009 American Medical Association. All Rights	ed.	ues are reflected for codes not payable by Medicare, please note that these values have been	Shed as a courtest to the general public and are not not used to Medicard in the DM is for CDT.	ougget neutrality reduction from the chropractic demonstration is not reflected in the KVOS out Cr. 1 18940–98941 and 98942. The required reduction will only be reflected in the files used for		is totals for maloractice RVUs may not sum due to rounding.	
Physi. Non- Facility Mai- cian Facility Facility Mai- Work PE Practice Dascription Pulls, Pul	A Transfer of abdominal muscle 11.21 NA 9.16 1.68	11.90 NA 9.50 1.78	13.63 NA 10.35 2.04	Transfer of iliopsoas muscle 12.46 NA 9.77 1.87	Reconstruction of hip socket 19.10 NA 13.24 2.86	Reconstruction of hip socket 15.95 NA 11.47 2.37	Partial hip replacement 16.46 NA 11.72 2.46	Total hip arthroplasty 21.61 NA 14.46 3.23	Total hip arthroplasty 25.49 NA 16.53 3.81	Revise hip joint replacement 30.13 NA 18.16 4.50	Revise hip joint replacement 22.55 NA 14.44 3.37	Revise hip joint replacement 23.55 NA 14.93 3.52	Transmiant femur ridge 12.66 NA 9.59 1.90	Incision of his bone 18.72 NA 13.17 2.80	Pevision of hin hone 21.87 NA 14.72 3.27	Indicion of his bone 73.07 NA 15.73 3.88	Description of this Leaves 26.03 NA 16.77 3.00	Revision of nip bones 20.03 INA 10.17 3.90	Kevision of peivis	Inclision of neck of female 17.74 19.74 12.31 2.04	incision/tixation of femuration of 14.14 2.99	Repair/graft temur head/neck 17.46 NA 11.93 2.01	reat Supped epiphysis 9.29 NA 7.22 1.39	Tent supped epipolosis 12.10 (A) 11.20 2.20	Treat slipped chiphysis 12.77 NA 9.93 1.91	Revise head/neck of femure 13.83 NA 10.35 2.07	Treat slinned eninhysis 15 98 NA 11.82 2.39	Revision of femure piphysis 9.67 NA 5.70 0.52	Reinforce hip bones 14.09 NA 10.55 2.11	Treat pelvic ring fracture 5.98 5.57 5.73 0.89	Treat pelvic ring fracture 10.08 NA 7.14 1.21	Treat tail bone fracture 1.87 2.52 2.69 0.26	Treat tail bone fracture 7.25 NA 5.93 1.09	10.45 NA 5.53 0.56	15.73 NA 8.00 0.84	14.65 NA 7.60 0.78	: 20.93 NA 9.89 1.12	6.72 6.33 6.22 1.00	13.97 NA 10.22 2.05	15.45 NA 10.95 2.31	25.21 NA 16.34 3.77	29.13 NA 18.27 4.36	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved.	' [f values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesty to me general pulsor and are not used to tweeting by such as the DVI is far CPT.	The budget deutranty reduction from the chropractic demonstration is not reflected in the KVDs for Critical Apparation by Apparation and 98940 Apparation and 98940. The required reclination will only be reflected in the files used for		Global totals for malgractice R VUs may not sum due to rounding.	6

	Global 090	060	000	060	3	060	060	060	060	060	060	060	060	060	060	060	060	000	060	860	060	060	060	060	260	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060				
Mak- Practice	RVUs ^{2,3,4}	15.1	120	6.79	4.	2.29	2.58	1.50	1.60	1.32	1.76	1.64	1.71	1.83	1.69	2.77	2.43	3.44	12.	2.17	2.84	1.98	2.08	2.76	2.56	167	2.78	1.32	1.50	0.70	1.35	3.12	4.02	2.60	2.45	1.00	1.15	1.28	1.39	16.0	0.94	1.65	pts	peen	VUs for CPT I for	
Facility PE	RVUs ²³ 8 34	4.0	6.23	5.03	×.	12.13	13.60	8.30	9.26	7.47	9.14	8.75	8.97	9.41	8.90	12.81	11.37	15.46	× 78	10.81	13.29	10,11	10.00	12.73	12.41	13.01	13.00	7.48	8.07	66'9	7.51	14,27	17.24	12.52	11.73	6.63	6.64	7.56	7.94	5.63	5.92	8.22	ion. All Rig	ralues have l ent.	ted in the R' he files used	
Non- Facility PE	RVUs ^{2,3}	Z Z	Ç :	K :	ď.	Y.	Y Y	¥Z	ΝA	NA NA	NA	Ϋ́	AN	NA	NA	Y.	. Y	Y N	Ç V	Z Z	Y Y	NA	NA	Ϋ́	Y ;	K Z	ζ <u>γ</u>	, K	Ϋ́	Ν	Ν	NA	N A	Ϋ́	V.	NA	NA	NA A	Ą Ż	6.55	6.02	Ϋ́Z	ical Associat	e that these v	is not reflect reflected in t	
Physi- cian Work	RVUe ²³	10.09	70.7	27.5	10.6	15,33	17.24	10.04	10.68	8.82	11.77	10.97	11.42	12.25	11.29	18.52	16.26	23.04	11.48	14.47	18.97	13.24	13.92	18.44	17.13	78.61	18.57	8.82	10.03	13.04	9.05	20.92	26.91	17.40	16,40	99.9	7.70	8.54	9.31	6.21	6.34	11.24	merican Med	re, please not	emonstration will only be	o rounding.
	Description	Revision of mistable kneeday	Nevisionicaloval of Aucecap	Lat retinacular release open	Reconstruction, knee	Reconstruction, knee	Reconstruction, knee	Revision of thigh muscles	Incision of knee joint	Revise kneecap	Revise kneecap with implant	Revision of knee joint	Revision of knee joint	Revision of knee joint	Revision of knee joint	Revision of knee joint	Revision of knee joint	Total trace surheconfacts	Total Auto at this planty	Incision of thish	Realignment of thigh bone	Realignment of knee	Realignment of knee	Shortening of thigh bone	Lengthening of thigh bone	Shorten/lengthen thighs	Repair of ungu Renair/oraft of thich	Surgery to stop leg growth	Surgery to stop leg growth	Surgery to stop leg growth	Surgery to stop leg growth	Revise/replace knee joint	Revise/replace knee joint	Removal of knee prosthesis	Reinforce thigh	Decompression of thigh/knee	Decompression of thigh/knee	Decompression of thigh/knee	Decompression of thigh/knee	Treatment of thigh fracture	Treatment of thigh fracture	Treatment of thigh fracture	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights teserved.	If values are reflected for codes not payable by Medicare, please note that these values have been bestablished as a courtesy to the general public and are not used for Medicare payment.	' The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dedicare payment. Global totals for malpractice RVUs may not sum due to rounding.
	Status	< <	۲.	∢ ·	∢	∢	∢	٧	4	4	∢	≺	V	¥	V	< <	: <	: <	ξ ⊲	< ∢	< <	~	¥	A	∢ .	< ≺	< 4	: <	· 4	¥	<	٧	<	4	<	⋖	ď	٧	∀	Ą	¥	٧	codes and c	nes are refl shed as a co	oudget neut 98940, 989	Medicare payment Global totals for
CPT ¹³ /	HCPCS Mod	27472	+7+/7	7/475	7747/	27428	27429	27430	27435	27437	27438	27440	27441	27442	27443	27445	27446	77477	27448	27450	27454	27455	27457	27465	27466	27468	27470	27475	27477	27479	27485	27486	27487	27488	27495	27496	27497	27498	27499	27500	27501	27502	_ 124	2 If va establi	, The t	Medic 4 Glob
	Global	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	222	000	060	960	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060			L.	
Mai- Practice																	-	•						1.19 090				060 260		1.81 090							2.03 090			2.10 090	1.70 090	1.51 090	ghts	been	VUs for CPT d for	
Facility Mal- PF Prantice	RVUs ^{2,1,4}		04.7	0.70	68.0		1.1		1.56	0.63		86:0	1.28	1.18	1.49	1 65	170	02.1	7.49		0.76	1.09	1.59	1.19	49.		1.10	76:0	1.28		1.20	1.87	1.38	1.27	1.34	1.60	2.03	3.67	2.96	2.10	1.70	8.33 1.51 090	tion. All Rights	values have been lent.	ted in the RVUs for CPT the files used for	
	RVUs ^{2,3} RVUs ^{2,4,4} C	1.87	10.57 2.40	4.80 0.70	5.76 0.89	1.24	6.92 1.11	1.35	1.56	4.83 0.63	5.89 0.89	6.32 0.98	7.56 1.28	6.97 1.18	8.27 1.49	591 506	170	0.10	0/:1 7:51	043 010	0.76	7.26 1.09	9.14 1.59	7.60 1.19	9.56 1.64	5.53 0.81	8.04 1.42	76:0	7.47	9,59 1.81	1.20	10.09 1.87	1.38	7.33 1.27	7.75 1.34	8.82 1.60	10.32 2.03	16.67 3.67	2.96	A 10.28 2.10	1.70	1.51	ical Association. All Rights	e that these values have been dicare payment.	is not reflected in the RVUs for CPT reflected in the files used for	
Facility	RVUs ²³ RVUs ²³ RVUs ^{23,4} C	NA 4.95 U.87	NA 10.5/ 2.40	NA 4.80 0.70	NA 5.76 0.89	NA 7.46 1.24	NA 6.92 1.11	1.35	8.51 1.56	NA 4.83 0.63	NA 5.89 0.89	NA 6.32 0.98	NA 7.56 1.28	NA 6.97 1.18	NA 8.27 1.49	NA 905 165	NA 2 33 071	001 CC 0 VN	NA 1271 2.69	147 043 010	9.74 4.87 0.76	NA 7.26 1.09	NA 9.14 1.59	NA 7.60 1.19	NA 9.56 1.64	NA 5.53 0.81	8.04 1.42	NA 6.02 0.97	NA 7.47 1.28	NA 9,59 1.81	NA 7.10 1.20	NA 10.09 1.87	NA 7.89 1.38	NA 7.33 1.27	NA 7.75 1.34	NA 8.82 1.60	NA 10.32 2.03	NA 16.67 3.67	NA 14,31 2,96	NA 10.28 2.10	A 9.12 1.70	1.51	merican Medical Association. All Rights	rre, please note that these values have been st used for Medicare payment.	demonstration is not reflected in the RVUs for CPT is used for in the files used for	o rounding.
Non- Facility Facility PF PF	Description RVUs ²³ RVUs ²³ RVUs ²³ C	Kemoval of thigh lesion 5.02 NA 4.93 U.81	Kemove tumor, inigin/knee 15.06 NA 10.57 2.40	Biopsy, knee joint lining 5.02 NA 4.80 0.70	Explore/treat knee joint 5.93 NA 5.76 0.89	Removal of knee cartilage 8.34 NA 7.46 1.24	Removal of knee cartilage 7.43 NA 6.92 1.11	Remove knee joint lining 9.07 NA 7.81 1.35	10.43 NA 8.51 1,56	Removal of kneecap bursa 4.23 NA 4.83 0.63	Removal of knee cyst 5.98 NA 5.89 0.89	Remove knee cyst 6.58 NA 6.32 0.98	Removal of kneedan 8.54 NA 7.56 1.28	Remove femur lesion 7.89 NA 6.97 1.18	Remove femur lesion/graft 9.97 NA 8.27 1.49	Persons femare legion/graft 1107 NA 005 165	Personal feature feature feature feature feature feature feature for A 73 NA 733 071	Designational for house, 11.24 MA 0.75 1.70	Extracticular numbers 17.04 NA 12.71 1.70	Trionting for page 2.07 Trionting for page 2.09 Trionting for page 2.09 Trionting for page 2.09 Trionting for page 2.09	Removal of foreign hody 5.12 9.74 4.87 0.76	Repair of kneecap tendon 7.34 NA 7.26 1.09	Repair/graff kneecap tendon 10.64 NA 9.14 1.59	Repair of thigh muscle 8.00 NA 7.60 1.19	Repair/graft of thigh muscle 10.99 NA 9.56 1.64	Incision of thigh tendon 5.44 NA 5.53 0.81	Incision of taign tendons 7.38 NA 9.77 1.10	Tenothening of thigh tendon 6.50 NA 6.02 0.97	Lengthening of thigh tendons 8.68 NA 7.47 1.28	12.10 NA 9.59 1.81	Transplant of thigh tendon 8.04 NA 7.10 1.20	12.46 NA 10.09 1.87	adons 9.21 NA 7.89 1.38	8.51 NA 7.33 1.27	8.96 NA 7.75 1.34	NA 8.82 1.60	NA 10.32 2.03	e 24.53 NA 16.67 3.67	NA 14,31 2,96	Osteochondral knee autograft 14.00 NA 10.28 2.10	NA 9.12 1.70	5 10.14 NA 8.33 1.51	and descriptions only are copyright 2009 American Medical Association. All Rights	e reflected for codes not payable by Medicare, please note that these values have been s a courtesy to the general public and are not used for Medicare payment.	neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT 98941, and 98942. The required reduction will only be reflected in the files used for	when the state of the sum of the sum the sum the sum that the sum tha
Non- Facility Facility PF PF	Les Description RVUs ²³ RVUs ²³ RVUs ²³ RVUs ^{23,4} C	3.02 NA 4.95 U.87	Kemove tumor, inigin/knee 15.06 NA 10.57 2.40	Biopsy, knee joint lining 5.02 NA 4.80 0.70	5.93 NA 5.76 0.89	8.34 NA 7.46 1.24	7.43 NA 6.92 1.11	Remove knee joint lining 9.07 NA 7.81 1.35	10.43 NA 8.51 1,56	4.23 NA 4.83 0.63	Removal of knee cyst 5.98 NA 5.89 0.89	Remove knee cyst 6.58 NA 6.32 0.98	Removal of kneedan 8.54 NA 7.56 1.28	7.89 NA 6.97	Remove femur lesion/graft 9.97 NA 8.27 1.49	Persons femare legion/graft 1107 NA 005 165	Personal feature feature feature feature feature feature feature for A 73 NA 733 071	Designational for house, 11.24 MA 0.75 1.70	Oue(s) (1.54 NA 7.72 1.70	Trionting for page 2.07 Trionting for page 2.09 Trionting for page 2.09 Trionting for page 2.09 Trionting for page 2.09	Removal of foreign hody 5.12 9.74 4.87 0.76	Repair of kneecap tendon 7.34 NA 7.26 1.09	Repair/graff kneecap tendon 10.64 NA 9.14 1.59	Repair of thigh muscle 8.00 NA 7.60 1.19	Repair/graft of thigh muscle 10.99 NA 9.56 1.64	5,44 NA 5,53 0,81	Incision of taign tendons 7.38 NA 9.77 1.10	Tenothening of thigh tendon 6.50 NA 6.02 0.97	Lengthening of thigh tendons 8.68 NA 7.47 1.28	12.10 NA 9.59 1.81	8.04 NA 7.10 1.20	12.46 NA 10.09 1.87	adons 9.21 NA 7.89 1.38	8.51 NA 7.33 1.27	8.96 NA 7.75 1.34	10.71 NA 8.82 1.60	13.57 NA 10.32 2.03	e 24.53 NA 16.67 3.67	19.79 NA 14.31 2.96	1 14.00 NA 10.28 2.10	11.46 NA 9.12 L.70	10.14 NA 8.33 1.51	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved.	if values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment. Global totals for malpractice R.V.Us may not sum due to rounding.

Reserved.

Tri Values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payanen.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice R VUs may not sum due to rounding.

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CPT'31		į		Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice		CPT ^{1,3} /	3		Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice	
2755 2755	DOM	Status		1 13	502	50	1 66	Contract	30977	5	Incision of a	2 80	07.5	1 03	920	,
205/2		< <	Treatment of thich fronting	CF 01	2 2	13.87	90.6	060	27606	(∢		4 15	` Z	3.09	0.54	
27507		< ∢	Treatment of thigh fracture	14.39	××	9.95	2.15	060	27607	< ≺		8.51	N.	18.9	1.18	
27508		₹	Treatment of thigh fracture	90.9	18.9	6.07	0.89	060	27610	¥		10.6	NA	7.30	1.22	
27509		<	Treatment of thigh fracture	8.02	NA	7.85	1.20	060	27612	V	Exploration of ankle joint	8.01	NA	90.9	0.85	
27510		<	Treatment of thigh fracture	89.6	ΝA	7.51	1.41	060	27613	₹	Biopsy lower leg soft tissue	2.19	4.14	1.97	0.18	-
27511		4	Treatment of thigh fracture	14.97	NA	9.93	2.23	060	27614	∢	Biopsy lower leg soft tissue	5.71	8.79	4.55	97.0	_
27513		٧	Treatment of thigh fracture	19.11	ΝA	11.96	2.85	060	27615	¥	Remove tumor, lower leg	12.93	NA V	8.94	1.95	
27514		¥	Treatment of thigh fracture	14.46	NA	19.6	2.16	060	27618	4	Remove lower leg lesion	5.14	4.	4.53	0.74	_
27516		∢	Treat thigh fx growth plate	5.45	6.87	6.13	0.82	060	27619	∢ ·	Remove lower leg lesion	8.47	11.62	6.30	1.13	
27517		A	Treat thigh fx growth plate	8.98	Y.	7.87	1.34	060	27620	∢ -	Explore/treat ankie joint	6.04	V.	4.5	87.0	- '
27519		¥	Treat thigh fx growth plate	13.11	Y.	10.6	1.96	060	27625	< ⋅	Remove ankle joint lining	8.37	V :	71.0	66.0	-
27520		∢	Treat kneecap fracture	2.93	4.86	4.19	0.43	060	27626	< •	Remove ankle joint lining	86.8	AN C	6.89	4.0	
27524		¥	Treat kneecap fracture	10.25	×.	8.40	1.53	060	27630	∢ .		58.4	70.6	4.32	85.0	-
27530		¥	Treat knee fracture	3.97	5.72	5.07	0.58	060	27635	< -		167	V ;	97.0	= 5	
27532		¥	Treat knee fracture	7.43	2.68	6.78	= :	060	27637	V.		10.17	ď.	8.05	701	
27535		¥	Treat knee fracture	13.27	Y.	60.6	86:1	060	27638	∢ .		10.87	۷ ; 2 ;	×. 6	50.	
27536		∢	Treat knee fracture	17.19	Y.	12.43	2.56	060	27640	∢ ·		12.10	ď;	×.85	50.7	
27538		Y	Treat knee fracture(s)	4.95	6.49	5.78	0.73	060	27641	∢ ·		9.73	ď.	7.24	97	
27540		¥	Treat knee fracture	11.16	ΝA	8.98	1.66	060	27645	∢ ·		14.78	Z ;	10.92	2.21	
27550		٧	Treat knee dislocation	5.84	6.28	5.43	0.80	060	27646	¥ ·		13.21	۷ ;	10.15	867	
27552		¥.	Treat knee dislocation	8.04	NA	7.35	1.20	060	27647	¥		12.85	Ϋ́,	6,45	16.0	
27556		٧	Treat knee dislocation	12.86	NA	8.89	1.92	060	27648	∢	_	0.96	3.21	0.41	0.10	
27557		V	Treat knee distocation	15.76	ΥN	10.32	2.36	060	27650	∢		00.6	ΨZ.	7.69	1.12	
27558		٧	Treat knee dislocation	18.25	ΝA	11.54	2.73	060	27652	≺	_	10.64	YZ :	7.00	Ξ:	
27560		∢	Treat kneecap dislocation	3.88	5.33	4.70	0.58	060	27654	∢ ·		10.32	Y Y	7.54	= ;	_
27562		4	Treat kneecap dislocation	5.86	NA	5.94	0.88	060	27656	∢ ·		4.62	10.75	5.06	69.0	
27566		٧	Treat kneecap dislocation	12.59	Y.	9.56	00 Y	060	27658	∢ .	,	5.03	AN ;	4.52	0.58	
27570		¥	Fixation of knee joint	1.76	Y :	1.93	0.26	010	27659	∢ ′		6.99	Y ;	4. 6	0.72	
27580		∢ ·	Fusion of knee	20.90	Y ;	14.99	3.1	060	27664	∢ -		4.04	V X	76.4	0.50	
27590		K.	Amputate leg at thigh	13.35	V.	1.57	2.21	080	500/7	< -		04.0	۲ ×	10.0	0.00	
1657.7		∢ .	Amputate leg at Inign	13.82	¢ ;	07.0	61.7	060	51017	< <	Repair lower leg tendous	17.0	V 2	3.21	1.5	
76517		٧ ٠	Amputate leg at mign	10.80	4 Z	0.38	6/-	060	27680	₹ •1	Release of lower leg tendon	0.0	Z Z	4 94	0.70	
27506		< ⊲	Amputation follow-up surgery	71.17	Z Z	7.23	28.	060	27681	. ∢	Release of lower leg tendons	6.94	Y Z	6.47	10.1	
27598		< ∢	Amoutate lower leg at knee	1.08	NA	7.63	1.76	060	27685	<	Revision of lower leg tendon	6.57	10.03	5.21	19.0	-
27599		U	Leg surgery procedure	00:00	0.00	0.00	0.00	YYY	27686	¥		7.64	NA	6.14	16'0	
27600		¥	Decompression of lower leg	5.94	ΝA	4.47	0.95	060	27687	<	Revision of calf tendon	6.30	N A	5.23	0.73	
27601		٧	Decompression of lower leg	5.94	NA	5.09	0.95	060	27690	•	Revise lower leg tendon	8.96	NA	7.08	86'0	
27602		4	Decompression of lower leg	1.71	NA	5.02	1.30	060	27691	•	Revise lower leg tendon	10.28	NA	8.58	1.35	
27603		٧	Drain lower leg lesion	5.12	8.22	4.67	0.74	060	27692	∢	Revise additional leg tendon	1.87	¥ Z	98.0	0.25	
27604		4	Drain lower leg bursa	4.51	7.38	3.95	0.53	060	27695	₹	Repair of ankle ligament	6.58	ΥZ	5.63	0.79	
	CPT	codes an	CPT codes and descriptions only are copyright 2009 American Me	vmerican Med	ical Associa	edical Association, All Rights	hts			CPT codes	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Med	lical Associat	ion. All Rig	ıts	
	Reserved.	/ed.	(eserved.) If unknown mallanted for ander not recorded by Madinara Inlesso note that these values have been	or accold	that thece	and saller	Less			Reserved.	Reserved. ? If values are reflected for codes not navable by Medicare in lease note that these values have been	are nlease not	te that these	zahies have b	een Gen	
	establis	shed as a	It values are reflected for codes from payable, by incurant, phease note that make stabilished as a courtesy to the general public and are not used for Medicare payment.	ot used for M	edicare payo	nent.				established a	established as a courtesy to the general public and are not used for Medicare payment	ot used for Me	edicare paym	ent.		
	The t	budget ne	onder 98040, 98041, and 98042. The required reduction will only be reflected in the RVUs for CPT	demonstration n will only be	is not reflected in	ted in the R'	70s for CPT I for			The budget codes 98940.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	demonstration n will only be	is not reflected in t	ted in the RV he files used	Us for CPT for	
	Medic	Medicare payment.	ent.							Medicare payment	ment					
	, Glob	al totals i	Global totals for malpractice RVUs may not sum due to rounding.	to rounding.						Global tota	Global totals for majpractice RVUs may not sum due to rounding	to rounding.				

is do	000	060	960	960	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	010	060	060	060	060	060	060	060	060	060	060	060	060	Y Y Y	010	000	960	260	060	060	960	260	000	n&n					
Mat Practice	1 64	1000	0.40	0.17	1.62	96.	0.45	0.95	1.59	2.15	2.70	1.26	0.58	69.0	1.50	19.0	06'0	1.46	1.69	0.28	2.10	1.39	2.50	2.10	19.1	1.40	1.59	1.46	1.80	1.23	1.26	86.	0.00	0.16	0.40	0.70	0.00	0.50	0.15	000	0.35	0.50	0.30	ghts	peen	VUs for CP	d for	
Facility PE DVIIs 23		57.0	3.98	5.15	5,83	10.79	4.18	5.73	6.79	12.24	14.08	8.36	4.74	5.11	8.59	4.25	5.78	8.15	8.93	2.00	10.88	7.86	8.24	8.88	5.86	6.04	6.90	7.18	6.02	6.03	5.92	8.82	90.5	79.	5.63	* o	3.07	2.0	7 t.2	00.0	3.53	10.0	5.30	tion. All Rij	values bave	ient. ted in the R	the files use	
Non- Facility PE	6 2	Š	0/.4	6.29	Ž:	V.	4.39	6.92	NA	NA	NA	ΝA	5.36	NA	ΥZ	Ν	ΝA	Ϋ́	Ϋ́Z	NA	NA	NA	Y.	Ϋ́	ΝA	NA	NA	NA	NA	Ϋ́Α	Y :	Y S	0.00	4.26	ŧ. 0	8,48 NA	7 V V	20,40	5.7	77.4	07.0	4.6	7.00	lical Associa	te that these	edicare payır ı is not reflec	reflected in	
Physi- clan Work		0.00	7.90	5.57	11.03	12.98	3.20	09.9	10.92	14.56	18.20	8.64	3.85	4.62	10.01	4.65	6.34	10.16	11.56	2.36	15.21	9.42	15.24	13.32	79.6	8.64	88.6	10.23	10.72	7.82	7.78	12.42	0.00	2.75	5.78	6.95	05.6	00.0	4 10	4.13	5.00	4.12	4.43	merican Med	rre, please no	ot used for M lemonstration	will only be	
C. C	Topological Control	Treatment of ankle fracture	reatment of ankle tracture	I reatment of ankle tracture	Treatment of ankle fracture	Treatment of ankle fracture	Treat lower leg fracture	Treat lower leg fracture	Treat lower leg joint	Treat lower leg dislocation	Treat lower leg dislocation	Treat lower leg dislocation	Treat ankle dislocation	Treat ankle dislocation	Treat ankle dislocation	Treat ankle dislocation	Fixation of ankle joint	Fusion of ankle joint, open	Fusion of tibiofibular joint	Amputation of lower leg	Amputation of lower leg	Amputation of lower leg	Amputation follow-up surgery	Amputation follow-up surgery	Amputation of foot at ankle	Amputation of foot at ankle	Decompression of leg	Decompression of leg	Decompression of leg	Leg/ankle surgery procedure	Dramage of bursa of foot	reament of foot infection	Treat foot bone lesion	Training of foot family	function of the tenden	Indicion of the tendon	mension of the features	Exploration of foot joint	Exploration of 1000 Jour	Exploration of toe joint	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights esserved.	If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chirograptic demonstration is not reflected in the RVUs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	-			
į	Similar.	< -	∢ .	Κ.	¥	Α.	¥	٧	٧	4	*	∢	4	A	∢	٧	×	¥	<	4	٧	V	¥	¥	<	٧	Ą	Ą	4	٧	∢ .	< '	. ن	∢ .	< -	< <	< <	< <	< -	٠.	< -	< -	₹	odes and d	ies are refl	hed as a co udget neutr	8940,989	And Alexander was seen
3																																												CPT coc	2 If valu	establisi The bu	codes 9	16.45
lev LdO	ָבָּיבְיבָּיבְיבָיבְיבָיבְיבָיבְיבָיבְיבָיבְיבָיבְיבָיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְיבְי	71914	27810	27818	27822	27823	27824	27825	27826	27827	27828	27829	27830	27831	27832	27840	27842	27846	27848	27860	27870	27871	27880	27881	27882	27884	27886	27888	27889	27892	27893	27894	27899	28001	20082	28003	28009	28008	28010	28020	07087	77007	28024					
	Giobal	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	000	060	060	060	060	060					
Mal- Practice	10.AK	68.5	7.17	68.0	1.99	2.40	1.05	1.52	0.67	2.55	2.35	2.30	1.81	1.84 1.84	2.85	2.57	5.09	2.20	1.14	0.29	0.47	1.42	1.57	1.55	0.47	16'0	1.09	1.85	2.13	0.42	0.74	Ξ	0.36	0.75	00.0	95.0	0.00	0 t 0	1.0	000	15.	0.41	0.74	ıts	ееп	payment. reflected in the RVUs for CPT	for	
Facility PE	200	0.00	9:18	5.90	10.21	11.78	6.62	8.31	5.28	11.99	11.68	11.20	09.6	9.70	12.59	12.97	10.09	11.00	6.81	5.57	5.28	7.97	8.70	8.42	4.45	6.07	98.9	9.73	10.55	4.33	5.47	7.31	4.34	5.67	× × ×	969	17.0	\$.23	70.4	0,4	8,13	9.30	5.35	sociation. All Rights	these values have been	nt. d in the RV	in the files used for	
Non- Facility PE	S A		Y Z	Ž	NA	NA	NA	NA	NA	NA	NA A	NA	N.A	NA	NA	NA	NA	NA	ΝA	N.	NA	NA	N.	NA	5.13	7.04	NA	NA	N.	5.03	6.42	NA.	4.30	Y :	K .	40.2	47.6	K 2	7. 4	2.07	AN 3	5.10	6.34	al Associatio	that these va	icare payment not reflected	flected in th	
Physi- cian Work		8.40	9.49	9.54	14.28	16.79	69''	10.74	4.67	17.32	15.67	15.36	12.22	12.31	19.18	17.15	14.20	14.69	7.59	5.37	8.72	9.49	10.49	10.37	3.26	6.15	7.33	12.40	14.31	3.09	5.33	7.73	2.50	5.00	0.00	2.72	14,4	10.6	16.7	4.32	50.6	16.7	5.20	merican Medic	re, please note	t used for Med	will only be re	
;	Describtion	Repair of ankle ugaments	Repair of ankle ligament	Revision of ankle joint	Reconstruct ankle joint	Reconstruction, ankle joint	Removal of ankle implant	Incision of tibia	incision of fibula	Incision of tibia & fibula	Realignment of lower leg	Revision of lower leg	Repair of tibia	Repair/graft of tibia	Repair/graft of tibia	Repair of lower leg	Repair fibula nonunion	Repair of lower leg	Repair of tibia epiphysis	Repair of fibula epiphysis	Repair lower leg epiphyses	Repair of leg epiphyses	Repair of leg apiphyses	Reinforce tibia	Treatment of tibia fracture	Treatment of tibia fracture	Treatment of tibia fracture	Treatment of tibia fracture	Treatment of tibia fracture	Cltx medial ankle fx	Cltx med ankle fx w/mnpj	Optx medial ankle fx	Cltx post ankle fx	Cltx post ankle fx w/mnpj	Optx post ankle fx	readment of fibula fracture	rearment of fibula fracture	reatment of houla bacture	rearment of ankle tracture	reatment of ankie tracture	reatment of ankle tracture	reatment of ankle fracture	Treatment of ankle fracture	CPT codes and descriptions only are copyright 2009 American Medical As Bearing	2 If values are reflected for codes not payable by Medicare, please note that	established as a courtesy to the general public and are not used for Medicare ³ The hidoet neutrality reduction from the chirotractic demonstration is not	codes 98940, 98941, and 98942. The required reduction will only be reflect	
	Status	∢	٧	4	¥	¥	٧	¥	¥	<	V	∢	∢	4	٧	٧	4	K	∢	∢	∢	¥	V	V	∢	Ą	∢	Ą	¥	٧	4	<	∢	< -	∢ .	∢ •	∢ -	< ⋅	∢ .	₹ .	∢ •	∢ .	<	codes and c	lues are refl	ished as a co	98940, 9894	
	CS Mod	~	•	_	۲.	~	-	14	Ŀ	~			_	٠.		100	-ر	7	_	٠		_	۰.	.~	_	٠.	,^	~	•	_	~	~	7	~	•	_			<u>.</u>	~	~ -	~		CPT cod	2 If va	estabil 3 The I	codes	
(c)TYO	Į.	27696	27698	27700	27702	27703	27704	27705	27707	27709	27712	27715	27720	27722	27724	27725	27726	27727	27730	27732	27734	27740	27742	27745	27750	27752	27756	27758	27759	27760	27762	27766	27767	27768	27769	27780	8//7	78/17	08//2	88/17	277792	27808	27810					

Reserved.

The first like are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neurality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 19840, 1984, 1, and 198942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

3	000	000	0.0	010	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	260	260	260	060	060	060	260	060	969						
Mai- Practice	27.0	77	0.00	0.13	0.35	0.41	0.33	0.47	0.35	0.44	0.30	0.36	0.25	0.25	0.28	0.24	0.25	0.63	0.32	0.57	0.77	0.92	2.31	0.57	0.36	0.22	0.42	0.33	0.28	0.48	0.72	0.52	0.61	9.00	0.69	0.55	0.80	0.63	13.0	07.	1.44	0.0	0.58	ıts	Sen		Us for CPT for	i	
Facility PE	908	00.0	0.70	1.48	3.43	3.83	3.37	4.13	3.51	4.13	3.23	3.45	2.84	3.05	3.00	2.85	3.33	4.83	3.16	4.30	5.30	6.59	11.57	4.85	3.73	2.75	3.81	3.59	3.18	5.14	5.88	4.35	6.62	7.16	5.17	5.30	2,88	5.03	71.0	±0.7	\$.03	2.02	6.72	on. All Rig	Hues have b	at.	ed in the RV of files used		
Non- Facility PE	8044	0.6	* !	4.4/	7.30	7.87	7.34	8.34	7.48	8.18	68'9	7,35	6.44	6.71	69'9	6,44	6.94	9.41	6.93	8.58	7.16	11.38	18.25	8.89	19.7	6.20	7.98	7.32	6.97	9.51	10.49	9.10	11.28	15.38	10.44	10.05	16.07	10.35	75.11	ξ.;	NA 0001	66.01	Y.	cal Associatio	that these va	dicare payme	is not reflects		
Physi- cian Work	8082	20.6	0.17	86.1	4.69	5.79	4.65	96.9	4.42	6.41	4.58	5.67	3.70	4.58	4.28	3.43	3.43	7.85	4.40	5.97	8.08	12.91	17.01	10.53	4.82	3.84	5.24	4.65	4.61	5.81	8.11	5.72	8.72	11.10	8.63	8.16	9.31	8.01	11.39	10.6	29.6	67.6	10.63	nerican Medi	re. please not	t used for Me	emonstration		rounding.
;	nonquised	calcusive root surgery	extensive tool surgery	Removal of toot foreign body	Removal of foot foreign body	Removal of foot foreign body	Repair of foot tendon	Repair/graft of foot tendon	Repair of foot tendon	Repair/graft of foot tendon	Release of foot tendon	Release of foot tendons	Release of foot tendon	Release of foot tendons	Incision of foot tendon(s)	Incision of toe tendon	Incision of foot tendon	Revision of foot tendon	Release of big toe	Revision of foot fascia	Release of midfoot joint	Revision of foot tendon	Revision of foot and ankle	Release of midfoot joint	Release of foot contracture	Release of toe joint, each	Fusion of toes	Repair of hammertoe	Repair of hammertoe	Partial removal of foot bone	Repair hallux rigidus	Correction of bunion	Correction of bunion	Correction of bunion	Correction of bunion	Correction of bunion	Correction of bunion	Correction of bunion	Correction of bunion	incision of neet bone	Incision of ankle bone	incision of infultor bones	incise/graft midfoot bones	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	ceserveα. If values are reflected for codes not navable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 08041, and 08042. The general reduction will only be reflected in the files used for	at.	Global totals for malpractice RVUs may not sum due to rounding.
	Scattle	٠.	€ '	4	Ą	٧	Y	¥	٧	¥	8	¥	V	٧	Y	A	¥	¥	¥	4	¥	¥	A	٧	٧	*	A	¥	٧	¥	Ą	٧	¥	Ą	K	∢ ·	∢ .	۷.	< ∙	₹ .	< <	Κ.	∢	odes and	ea. Ies are refi	hed as a co	udget neut	Medicare payment.	il totals for
	DOM																																											CPTC	Z If values	establis	The b	Medica	4 Globa
CPT ^{1.3}	20175	C/ 107	28113	28190	28192	28193	28200	28202	28208	28210	28220	28222	28225	28226	28230	28232	28234	28238	28240	28250	28260	28261	28262	28264	28270	28272	28280	28285	28286	28288	28289	28290	28292	28293	28294	28296	28297	28298	28299	78300	28302	58304	28305						
Mal- Practice	9		060 /70	0.37 090						0.40 090				0.34 090	0.54 090	0.40 090			060 22		0.36 0.90		0.39 090				0.43 090					0.55 090		0.58 090					0,67		0.26 0.90		0.53 090	hts	G 4		reflected in the RVUs for CPT		
Facility	4AUS.	10.4	7.90	3.54	6.20	2.98	3.38	2.61	3.65	3.82	3.98	3.63	40.4	4.54	4.29	3.53	3.44	3.24	4.52	4.16	3.71	3.70	4.02	3.48	3.18	3.26	3.50	3.49	4.95	9.56	5.61	4,45	3.84	4.54	5.23	3.62	2.84	88.9	4.49	5.21	3.12	3.19	5.15	a. All Rigl	these values have been	t.	in the RV	200	
Non- Facility PE	RVUs"	67.8	5.73	7.77	11.16	6.54	7.45	90.9	N.	77.7	8.36	7.75	8.54	8.40	8.85	7.78	7.45	7.10	9.20	NA	Y.	7.86	N.	7.62	88.9	7.52	7.81	7.85	60.6	15.44	10.13	8.85	7.88	9.26	9.34	7.24	6.49	N.	8.56	6.90	6.82	6.99	ΑN	al Associatio		icare payment.	s not reflected	און דו האאמיוו	
Physi- cian Work	KVUs	5.14	3.58	4.77	10.55	4.30	3.98	3.49	6.20	5.29	6.58	5.15	4.63	4.65	4.83	3.90	4.46	3.69	5.72	7.80	6.56	5.17	7.23	5.62	4.21	4.13	5.06	4.54	5.88	11.61	8.94	6.02	5.45	5.64	7.56	4.88	3.56	9.30	7.03	4.4	3.71	8.79	9.85	nencan Medic	eton escela e	t used for Med	emonstration i	with Outly Oc. 18	rounding.
	Mod Status	A Decompression of tibia nerve	A Excision of foot lesion	A Excision of foot lesion	A Resection of tumor, foot	A Biopsy of foot joint lining		A Bionsy of toe joint lining	A Neurectomy, foot	A Partial removal, foot fascia	A Removal of foot fascia	A Removal of front ining	A Removal of foot joint lining	A Removal of foot lesion		_				A Remove/graft foot lesion		_				A Part removal of metatarsal						A Removal of heel bone	A Removal of heel spur	A Part removal of ankle/heel	 A Partial removal of foot bone 	A Partial removal of toe	A Partial removal of toe	A Removal of ankle bone	A Removal of metatarsal	A Removal of toe	A Partial removal of toe	A Partial removal of toe	 A Extensive foot surgery 	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. 2 16 volume are reflected for codes not noveltle by Medicere inlease note that	established as a courtesy to the general public and are not used for Medicare	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs	Medicare payment.	⁴ Global totals for malpractice RVUs may not sum due to rounding.
CPT ⁽⁻³)	HCPCS	28035	28043	28045	28046	28050	28052	28054	28055	28060	28062	28070	28072	28080	28086	28088	28000	28002	28100	28102	28103	28104	28106	28107	28108	28110	28111	28112	28113	28114	28116	28118	28119	28120	28122	28124	28126	28130	28140	28150	28153	28160	28171						

Global	060	060	060	060	060	060	060	060	060	060	060	060	010	010	010	060	010	010	010	060	060	060	060	060	060	060	060	060	060	060	060	060	9 8	260	260	22		900	200	8 8	9	8							
Mal- Practice RVUs ^{2 3,4}	0.14	0.38	0.49	1.17	60.0	0.51	0.67	1.22	0.21	0.42	0.64	1.29	0.15	0.15	0.31	0.59	0.12	0.17	0.40	0.56	2.59	1.86	1.40	1.43	1.30	0.93	66'0	96'0	0.38	0.76	86.0	1.58	0.87	0.54	797	07:0	0.00	12.0	300	0.07	270		gnts	peen	M. S. Cor C.D.T.	d for			
Facility PE RVUs ^{2,3}	2.46	3.8]	16.4	7.31	1.85	4.60	5.14	7.90	2.72	4.31	4.85	9.07	1.07	1.4	2.31	4.97	96'0	1.47	2.60	4.98	12.69	10.04	7.86	9.02	8.04	95.9	68.9	08.9	3.62	5.93	5.61	9.09	9 6	4.5	4.5.4 6.5.4	400	2,000	0.86	35.5	06.3	2.12	£ 1.7	ion. All Ki	alues have	ent.	he files use			
Non- Facility PE RVIIs ²³	2.95	4.63	69:01	12.50	2.42	5.44	Ϋ́	13,13	3.47	5.10	NA	ΑN	2.16	2.45	4,96	9.11	1.59	2.04	۷ Z	9.29	Ϋ́	Ϋ́Z	Ϋ́	ΝĀ	NA	Ϋ́	12.51	12.45	7.97	11.23	NA NA	Y Z	YY S	8.42	8.90	2.0	2,63	2.00	25.0	3.74	177	; ;	ical Associal	e that these	edicare paym	reflected in t			
Physic clan Work RVIIs ²³	2.10	2.51	3.28	9.49	1.70	3.38	4.48	10.92	1.94	2.78	4.97	10.46	1.72	1.93	2.77	7.28	1.25	1.94	5.66	5.46	20.12	14.40	11.97	12.21	12.03	10.83	60'6	8.37	4.79	8.94	8.65	12.55	6.52	4.89	5.85	000	3.76	2.06	20.4	+'7 	2.40	7.	merican Med	re, please no	t used for Mi	will only be	•	rounding.	
Dearrintfon	Treat foot dislocation	Treat foot dislocation	Treat foot dislocation	Repair foot dislocation	Treat foot dislocation	Treat foot dislocation	Treat foot dislocation	Repair foot dislocation	Treat foot dislocation	Treat foot dislocation	Treat foot dislocation	Repair foot dislocation	Treat toe dislocation	Treat toe dislocation	Treat toe dislocation	Repair toe dislocation	Treat toe dislocation	Treat toe dislocation	Treat toe dislocation	Repair of toe dislocation	Fusion of foot bones	Fusion of foot bones	Fusion of foot bones	Fusion of foot bones	Fusion of foot bones	Revision of foot bones	Fusion of foot bones	Fusion of big toe joint	Fusion of big toe joint	Fusion of big toe joint	Amputation of midfoot	Amputation thru metatarsal	Amputation toe & metatarsal	Amputation of toe	Partial amputation of toe	Footbas concept cown, prantal i	Authorition of Local cost	Application of body cast	A militarities of body cast	Application of body cast	Aminotion of hody care	Application of body cast	C.F.I. codes and descriptions only are copyright 2009 American Medical Association. All Kights	occurrent. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The hydron magnetic reduction from the chirametric demonstration is not reducted in the DMI see DM	i ne budget treutany feuterioù nom tre cantopractic ternoùssiartoù is not reflected in the fries codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	11.	Global totals for malpractice RVUs may not sum due to rounding.	
S. sides	4	₹	4	۷	¥	٧	¥	K	<	4	٧	4	4	٧	٧	∢	٧	∢	∢	¥	4	۷	V	V	¥	∢	¥	<	<	¥	∢ '	V	< ⋅	∢ -	< <	<i>د</i> د	- د	< ⊲		₹ 4	: <		codes and o	ues are refl	shed as a co	48940, 989	Medicare payment	I totals for	
CPT ^{UJ} / HCPCS Mod		28545	28546	28555	28570	28575	28576	28585	28600	28605	28606	28615	28630	28635	28636	28645	28660	28665	28666	28675	28705	28715	28725	28730	28735	28737	28740	28750	28755	28760	28800	28805	28810.	28820	28825	06887	20000	20062	20012	29070	3002		CPI coc	² If val	establi	codes	Medic	. Globa	
- September 1	060	. 060	060	060	060	960	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	040	040	060	500	060	000	020			Ļ	-			
Mat- Practice	0.61	96'0	0.43	1.57	0.39	0.36	0.53	0.35	1.04	0.97	0.38	0.47	0.23	0.32	2.38	0.27	0.50	0.88	2.09	2.59	0.26	0.52	0.72	2.08	2.62	0.22	0.33	0.41	0.94	0.24	0.29	0.39	0.70	0.12	0.13	07.0	00.0	2.0		0.02	0.14	t :	gnts	peen	Ville for C	d for			
Facility PE BVIsa ^{2,3}	4.50	6.20	4.24	8.82	3.63	3.53	4.20	3.44	6.45	6.33	3.83	4.38	2.98	3.57	67.6	3,39	4.14	6.51	12.04	13.70	3.01	4.37	6.14	11.23	12.84	2.80	3.64	5.13	6.77	2.76	2.80	4.92	6.23	96.	2.09	5.6	1 20 1	6.0	107	60:7	7	-0.5	tion. All Ki	values have	tent.	ted in the files used for			
Non- Facility PE BVI 16.2.3	9.77	12.88	8.83	NA	8.19	8.19	8.50	7.27	NA	11.55	7.93	8.83	6.62	7.47	NA	3.91	4.99	NA	NA	NA	3.64	5.29	NA	NA	NA	3.37	4.40	N.	ΝĄ	3.28	3.50	ΥZ	Y.	2.45	2.77	47.0	5.5	25.0	2.7	0.09	0.33		ical Associa	e that these	dicare payn	is not reflected in			
Physi- clan Work	5.91	6.39	5.36	13.96	5.48	4.60	5.06	16.4	9.25	8.41	7.04	8.60	4.31	5.98	14.67	2.22	4.63	6.44	15.96	17.29	2.14	3.45	4.78	15.53	17.50	1.95	3.15	2.75	8.64	1.99	2.97	3.46	7.28	1.12	1.62	4.54	07.7	71.1		0.40	19.6	10.7	mencan Med	re, please not	ot used for Me	will only be	,	o rounding.	
Mad Restat	A Incision of a	A Incision of metatarsal	A Incision of metatarsal	A Incision of metatarsals	A Revision of big toe	A Revision of toe	A Repair deformity of toe	A Removal of sesamoid bone	A Repair of foot bones	_	•		A Repair extra toe(s)	A Repair webbed toe(s)	A Reconstruct cleft foot	A Treatment of heel fracture	A Treatment of heel fracture	A Treatment of heel fracture	A Treat heel fracture	į	į	A Treatment of ankle fracture	 A Treatment of ankle fracture 		 A Osteochondral talus autogrift 	 A Treat midfoot fracture, each 	 A Treat midfoot fracture, each 	 A Treat midfoot fracture 	 A Treat midfoot fracture, each 	A Treat metatarsal fracture		 A Treat metatrasal fracture 	A Treat metatarsal fracture	A Treat big toe tracture			A Ireal oig toe tracture			A Treat commoid hous fracture	•	A Heat sesation bone tracime	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	reserved. 2 If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	i ne buaget neuraniy reduction from the catropractic acmonstration is not rejected in the NVS for Criticoles 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	"Global totals for malpractice RVUs may not sum due to rounding.	
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i ⁶ lma2				Physi- cian	Non- Facility	Facility	Mai-		161 TG 2			Physi- cian	Non- Facility pr	Facility	Mal- Practice	
HCPCS	Mod	Status	_	RVUs.3	RVUs.23	RVU ₈ 23	RVUs ^{2.3.4}	Global	. en	Mod Status		RVUs ^{2,3}	RVUs.3	RVUs ^{2,3}	RVUs23.	<u> </u>
29035		¥	Application of body cast	1.77	4.03	1,66	0.26	000	29705	∢	Removal/revision of cast	0.76	0.92	0.45	0.10	_
29040		Æ	Application of body cast	2.22	3.80	1.68	0.33	000	29710	¥	Removal/revision of cast	7.34	1.71	0.77	0.20	_
29044		⋖	Application of body cast	2.12	4.27	1.84	0,32	000	29715	∢	Removal/revision of cast	0.94	1.09	0.43	90:0	U
29046		V.	Application of body cast	2.41	4.33	1.93	0.36	000	29720.	4	Repair of body cast	99'0	1.37	0.42	0.10	٠
29049		∢	Application of figure eight	0.89	1.12	0.63	0.13	000	29730	Y	Windowing of cast	0.75	68.0	0.42	60.0	_
29055		K	Application of shoulder cast	1.78	3.66	1.67	0.27	000	29740	٧	Wedging of cast	1.12	1.14	0.52	0.13	0
29058		∢	Application of shoulder cast	1.31	1.51	0.70	0.14	000	29750	<	Wedging of clubfoot cast	1.26	1.40	0,71	61.0	0
29062		ď	Application of long arm cast	0.87	1.51	0.85	0.12	000	29799	၁	Casting/strapping procedure	0.00	0.00	00.0	0.00	>
29075		∢	Application of forearm cast	0.77	1.46	0.80	0.11	000	29800	*	Jaw arthroscopy/surgery	6.73	Ν	6.22	1.01	_
29085		¥	Apply hand/wrist cast	0.87	1.50	0.84	0.11	000	29804	¥	Jaw arthroscopy/surgery	8.71	NA A	6.23	0.24	_
29086		¥.	Apply finger cast	0.62	1.33	0.70	90.0	000	29805	¥	Shoulder arthroscopy, dx	5.94	ΝA	5.66	0.88	_
29105		∢	Apply long arm splint	0.87	131	99.0	0.10	000	29806	¥	Shoulder arthroscopy/surgery	14.95	NA A	11.36	2.22	0
29125		¥	Apply forearm splint	0.59	1.17	0.53	90:0	000	29807	K	Shoulder arthroscopy/surgery	14.48	NA	11.16	2.15	0
29126		∢	Apply forearm splint	0.77	1.23	0.61	80.0	000	29819	A	Shoulder arthroscopy/surgery	7.68	NA	6.79	1.14	0
29130		A	Application of finger splint	0.50	0.53	0.24	0.05	000	29820	¥	Shoulder arthroscopy/surgery	7.12	Y.	6.23	90'1	0
29131		¥	Application of finger splint	0.55	0.74	0.31	0.05	000	29821	A	Shoulder arthroscopy/surgery	7.78	NA A	6.85	1.16	0
29200		K	Strapping of chest	9.65	0.77	0.44	0.03	000	29822	¥	Shoulder arthroscopy/surgery	7.49	ΥZ	6.73	1.1	0
29220		٧	Strapping of low back	0.64	0.77	0.45	0.03	000	29823	<	Shoulder arthroscopy/surgery	8.24	NA	7.31	1.23	0
29240		₹.	Strapping of shoulder	0.71	0.76	0,44	0.04	000	29824	¥	Shoulder arthroscopy/surgery	8.82	NA	7.91	131	0
29260		4	Strapping of elbow or wrist	0.55	0.77	0.43	0.04	000	29825	4	Shoulder arthroscopy/surgery	7.68	ΝA	18.9	1.14	0
29280		٧	Strapping of hand or finger	0.51	0.77	0.43	0.03	000	29826	٧	Shoulder arthroscopy/surgery	9.05	NA	7.50	1.35	0
29305		¥	Application of hip cast	2.03	4.02	1.94	0.30	000	29827	٧	Arthroscop rotator cuff repr	15.44	ΑN	11.36	2.29	0
29325		V	Application of hip casts	2.32	4.39	2.14	0.35	000	29828	A	Arthroscopy biceps tenodesis	13.00	NA	86.6	1.94	0
29345		∢	Application of long leg cast	1.40	1.97	1.14	0.20	000	29830	¥	Elbow arthroscopy	5.80	ΝA	5.39	0.87	0
29355		¥	Application of long leg cast	1.53	1.96	1.15	0.21	000	29834	A	Elbow arthroscopy/surgery	6.33	NA VA	5.87	0.92	0
29358		∢	Apply long leg cast brace	1,43	2.51	1.17	0.21	000	29835	¥	Elbow arthroscopy/surgery	6.53	NA	2.97	86.0	0
29365		V	Application of long leg cast	1.18	1.85	1.02	0.17	000	29836	∢	Elbow arthroscopy/surgery	7.61	Y.	6.78	1.14	0
29405		₹ .	Apply short leg cast	0.86	65 .	0.77	0.11	000	29837	∢ ⋅	Elbow arthroscopy/surgery	6.92	ď;	6.18	707	٠ ر
29425		∢ .	Apply short leg cast	<u> </u>	0.40	0.75	0.10	000	29838	< ⋅	Elbow arthroscopy/surgery	7.77	Y.	6.86	1.12	<i>-</i>
29435		۷.	Apply short leg cast	87.	1.77	0.96	0.16	000	29840	∢ •	Wrist arthroscopy	5.59	Ϋ́ Z	5.51	0.84	J
29440		∢ •	Addition of walker to cast	0.57	0.77	75.0	0.07	000	29843	∢ •	wrist arthroscopy/surgery	0.00	e :	58.6	0.91	ی د
29445		∢ <	Apply rigid leg cast	8/	08.1	50.1	0.17	000	29844	< <	Wrist arthroscopy/surgery	24.0	4 × 2	5.99	1.03	ے ر
00400		< <	Application of leg cast	2.08	6.	26.0	0.13	000	29845	< ≺	Wrist and accept/surgery	0.70	C 2	10.0	50.1	ے د
29303		< 4	Application fougates splint	0.09	7	0.55	0.07	000	29840	< 4	Wrist arthrocopy/surgery	7.13	K Z	6.16	1.07	ے ر
29520		< <	Stranome of hip	0.54	0.72	0.40	0.03	000	29848	: <	Wrist endoscopy/surgery	6.24	Y.	6.35	0.87	
29530		: ∢	Stranoing of knee	0.57	0.76	0.42	0.0	000	29850	. A	Knee arthroscopy/surgery	8,18	N A	7.23	1.32	
29540		<	Strapping of ankle and/or ft	0.51	0.58	0.32	0.03	000	29851	A	Kaee arthroscopy/surgery	13.08	NA	96.6	1.96	φ
29550		A	Strapping of toes	0.47	09'0	0.31	0.03	000	29855	¥	Tibial arthroscopy/surgery	10.60	Ν	8.84	1.59	0
29580		٧	Application of paste boot	0.55	08.0	0.38	0.05	000	29856	A	Tibial arthroscopy/surgery	14.12	Y Y	10.57	2.11	9
29590		4	Application of foot splint	0.76	0.64	0.26	0.04	000	29860	A	Hip arthroscopy, dx	8.85	NA	7.56	1.32	٥
29700		¥	Removal/revision of cast	0.57	1.05	0.30	0.07	000	29861	Y	Hip arthroscopy/surgery	9.95	Ϋ́	8.10	1.49	9
	CPT	codes an	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Me	dical Associa	tion. All Rig	hts			PT codes a	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associat	ioa. All Rig	pts	
	Reserved.	ved. hang are re	Reserved. * I finalise are reflected for codes not navable by Medicare infease note that these values have been	nare mease	as that these	value have	neen		Re 2 Re	Reserved.	Reserved. ? !fushing are reflected for codes not navishie by Medicare in lease note that these values have been	are please not	that these	H eyec have h	E 9	
	establi	ished as a	established as a courtesy to the general public and are not used for Medicare payment	not used for M	edicare payn	lent.			ısə	ablished as	established as a courtesy to the general public and are not used for Medicare payment	ot used for Me	dicare paym	ent.	3	
	The (budget ne	The budget neutrality reduction from the chivopractic demonstration is not reflected in the RVUs for CPT	c demonstration	n is not reflec	is not reflected in the RVUs	7Us for CPT		L &	he budget n	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 00040. The general production will confuse a confused in the files used for	demonstration	is not reflect	ed in the RV	Us for CPT	
	Medic	Medicare payment	ient.	on will oury on		naca cant am	5		Ň	Medicare payment.	nent.	a was carry over		no rivo	121	
	4 Glob	al totals t	Global totals for malpractice RVUs may not sum due to rounding.	e to rounding.					9	ilobal totals	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				

	Global	010	060	060	060	060	060	060	060	060	060	060	XX	000	010	010	010	010	060	060	060	060	060	060	060	060	060	060	060	060	060	010	060	060	060	060	010	010	000	900	000	000	060									
Mal- Practice	RVUs. 3.4	0.11	0.43	0.31	86.0	0.63	0.32	0.70	0.32	0.34	1.06	96.0	0.00	0.05	0.07	0.10	70.0	0.13	0,44	1.03	1.34	1.78	1.19	1.21	1.89	1.53	1.96	130	29.0	0.76	0.62	60.0	0.27	0.59	0.67	0.73	0.07	0.14	0.10	0.12	91.0	0.17	0.73	hts		жеп		/Us for CPT	for			
Facility PE	RVUs ^{2,3}	69.1	9.9	5.37	08'6	5.78	3.85	8.40	6.25	7.6	10.28	10.05	0.00	0.78	1.43	1.65	2.13	3.26	6.93	14.97	16.45	18.32	13.74	15.85	19.11	10.46	16.22	12.92	9.02	62.6	10.42	2.22	5.55	5.01	9.71	8.76	2.34	2.81	0.42	0.58	69.0	1.07	7.55	ion, All Rie	2	alues have t	ent.	ed in the R	he files used			
Non- Facility PE	RVUs23	4.16	ď Z	18.65	۷ Z	7.75	V V	Y.	V.	K K	NA A	N A	0.00	2.13	2.68	6.07	4.71	ΥN	NA.	Ϋ́	NA	ΥN	NA	ď Z	K Z	۷ Z	Ϋ́	NA	Ν	ΑN	Ϋ́	5.50	99.8	8.54	Y Z	Y Z	4.60	5.28	1.47	3.57	4.35	4.68	ΥZ	cal Associat		e that these v	dicare paym	is not reflect	reflected in t			
Physi- cian Work	RVUs.3	1.65	4.38	3.20	18.6	5.31	3.14	7.21	3.41	3.48	9,44	88.6	0.00	0.78	1.10	1.56	1.06	1.98	4.56	10.58	13.72	16.62	1.96	12.45	19.38	10.24	20.12	12.20	6.85	7.81	11.50	1.28	6.76	6.07	6.04	7.18	Ξ	2.05	1.21	1.54	1.97	2.45	7.36	rerican Med		e, please not	used for Me	monstration	will only be	:	rounding.	
	Description	Removal of nose polyp(s)	Removal of nose polyp(s)	Removal of intranasal lesion	Removal of intranasal lesion	Revision of nose	Removal of nose lesion	Removal of nose lesion	Excise inferior turbinate	Resect inferior turbinate	Partial removal of nose	Removal of nose	Pre-prxd rsk et al docd	Injection treatment of nose	Nasal sinus therapy	Insert nasal septal button	Remove nasal foreign body	Remove nasal foreign body	Remove nasal foreign body	Reconstruction of nose	Reconstruction of nose	Reconstruction of nose	Revision of nose	Revision of nose	Revision of nose	Revision of nose	Revision of nose	Repair nasal stenosis	Repair of nasal septum	Repair nasal defect	Repair nasal defect	Release of nasal adhesions	Repair upper jaw fistula	Repair mouth/nose fistula	Intranasal reconstruction	Repair nasal septum defect	Ablate inf turbinate, superf	Cauterization, mner nose	Control of nosebleed	Control of nosebleed	Control of nosebleed	Repeat control of nosebleed	Ligation, nasal sinus artery	CPT codes and descriptions only are convright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	£.	Global totals for malpractice RVUs may not sum due to rounding	
	Statue	4	¥	¥	Y	4	¥	A	٧	¥	Ą	٧	_	٧	A	Ą	¥	¥	¥	æ	ď	œ	œ	×	œ	¥	∢	۷	∢	K	∢	4	¥	K	K	∢	4	₹	4	∢	٧	¥	¥	odes and c	'n.	ies are refl	hed as a co	ndget neut	8940, 989	Medicare payment	totals for	
	Mod																																											CPT	Reserved.	² If valu	establis	The b	codes 9	Medica	. Cloba	
CPT ^{1,3} /	HCPCS	30110	30115	30117	30118	30120	30124	30125	30130	30140	30150	30160	3018F	30200	30210	30220	30300	30310	30320	30400	30410	30420	30430	30435	30450	30460	30462	30465	30520	30540	30545	30560	30580	30600	30620	30630	30801	30802	30901	30903	30905	30906	30915									
Mat- Practice		1.63 090						060 860																	1.23 090		0.35 090		0.84 090					0.97 090			1.35 090		0.65 090	•	0.10 01.0	0.10 0.10	000 000	ehts		been		VUs for CPT	d for			
_	RYUS 2.3.4	1.63	1.64	2.17	2.72	3.73	0.76		16.0	1.05	0.95	1.30	1.22	1.32	1.39	1.28	1.41	1.73	1.22	1.50	1.25	1,49	2.11	2.54	1.23	1.51		0.91	0.84	0.92	96'0	2.15	0.31		1.91	1.27	1.35	1.42	9.65	00:0	0.10	0.10		ion. All Rights	·	alues have been	ent.	ed in the RVUs for CPT	he files used for			
Mal- Practice	RVUs ²³ RVUs ^{23,4} (9,20 1.63	9.24 1.64	11.46 2.17	13.52 2.72	16.82 3.73	5.03 0.76	86.0	16.0	6.19 1.05	5.87 0.95	7.46 1.30	1.22	7.52 1.32	7.75 1.39	7.39 1.28	7.79 1.41	9,19 1.73	7.19 1.22	8.49 1.50	7.31 1.25	8,43 1,49	2.11	12.98 2.54	7.78 1.23	8.81 1.51	4.84 0.35	5.64 0.91	0.84	5.73 0.92	96'0 80'9	10.90 2.15	4.42 0.31	0.97	8.04 1.91	7.19 1.27	7.94 1.35	8.38 1.42	9.63 0.65	0.00 0.00	1.57 0.10	0.10	90'0	ical Association. All Rights		e that these values have been	dicare payment.	is not reflected in the RVUs for CPT	reflected in the files used for			
Non- Facility Facility Mal- PE PE Practice	RVUs" RVUs" RVUs"	NA 9,20 1.63	9.24 1.64	NA 11.46 2.17	13.52 2.72	NA 16.82 3.73	NA 5.03 0.76	NA 6.08 0.98	NA 6.70 0.91	NA 6.19 1.05	NA 5.87 0.95	NA 7.46 1.30	NA 7.19 1.22	NA 7.52 1.32	NA 7.75 1.39	NA 7.39 1.28	NA 7.79 1.41	9,19 1.73	7.19 1.22	8.49 1.50	NA 7.31 1.25	NA 8,43 1,49	NA 10.49 2.11	NA 12.98 2.54	NA 7.78 1.23	NA 8.81 1.51	9.36 4.84 0.35	NA 5.64 0.91	NA 5.31 0.84	NA 5.73 0.92	NA 6.08 0.96	NA 10.90 2.15	NA 4.42 0.31	NA 6.58 0.97	NA 8.04 1.91	NA 7.19 1.27	NA 7.94 1.35	NA 8.38 1.42	9.63 0.65	0.00 0.00	1.57 0.10	0.10	0.85 0.06	nerican Medical Association. All Rights		e, please note that these values have been	used for Medicare payment.	monstration is not reflected in the RVUs for CPT	will only be reflected in the files used for	-	rounding.	
Physi. Non- cian Facility Mat- Work PE PE Practos	RVUS"3 RVUS"3 RVUS"3 RVUS"3"4	NA 9,20 1.63	NA 9.24 1.64	NA 11.46 2.17	NA 13.52 2.72	w/scpe 24.89 NA 16.82 3.73	Knee arthroscopy, dx 5.11 NA 5.03 0.76	Knee arthroscopy/drainage 6.60 NA 6.08 0.98	6.09 NA 6.70 0.91	7.10 NA 6.19 1.05	Knee arthroscopy/surgery 6.36 NA 5.87 0.95	Knee arthroscopy/surgery 8.72 NA 7.46 1.30	Knee arthroscopy/surgery 8.15 NA 7.19 1.22	Knee arthroscopy/surgety 8.84 NA 7.52 1.32	9.30 NA 7.75 1.39	Knee arthroscopy/surgery 8.56 NA 7.39 1.28	Knee artbroscopy/surgery 9.45 NA 7.79 1.41	Knee arthroscopy/surgery 11.61 NA 9.19 1.73	Knee arthroscopy/surgery 8.13 NA 7.19 1.22	Knee arthroscopy/surgery 10.03 NA 8.49 1.50	Knee arthroscopy/surgery 8.34 NA 7.31 1.25	Knee arthroscopy/surgery 9.98 NA 8.43 1.49	14.14 NA 10.49 2.11	Knee arthroscopy/surgery 17.15 NA 12.98 2.54	Ankle arthroscopy/surgery 9.47 NA 7.78 1.23	Ankle arthroscopy/surgery 10.07 NA 8.81 1.51	Scope, plantar fasciotomy 6.08 9.36 4.84 0.35	Ankle arthroscopy/surgery 7.26 NA 5.64 0.91	Ankle arthroscopy/surgery 7.04 NA 5.31 0.84	Ankle arthroscopy/surgery 7.23 NA 5.73 0.92	8.38 NA 6.08 0.96	. 15.21 NA 10.90 2.15	5.74 NA 4.42 0.31	NA 6.58 0.97	NA 8.04 1.91	myl 8.50 NA 7.19 1.27	9.00 NA 7.94 1.35	NA 8.38 1.42	NA 9.63 0.65	0.00 0.00 0.00 0.00	1.45 4.37 1.57 0.10	4.40 1.60 0.10	2.67 0.85 0.06	'CPT codes and descriptions only are convribbt 2009 American Medical Association. All Rieths	Reserved	² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	I, and 98942. The required reduction will only be reflect	Medicare payment	"Global totals for malpractice RVUs may not sum due to rounding.	

400	010	010	λ,	060	060	060	060	260	060	060	060	060	060	060	060	060	3 8	90	000	000	000	000	000	000	8 8	000	000	000	9 8	8 8	000	000	000	000	9	000	900	000			
Mal- Practice	1.13	1.31	0.00	1.53	0.55	2.94	3.83	3.10	2,66	2.51	2.46	2.75	4.41	4.24	1.12	01.1	0.19	0.00	0.14	0.17	0.13	0.14	0.14	0.17	0.18	0.21	91.0	0.18	0.24	0.23	0.23	0.27	0.30	0.41	0.63	0.35	0.40	0.26	ghts	VUs for CPT	5
Facility PE BVII.a ^{3,3}	11.12	12.45	0.00	16,99	10.01	24.24	28.45	20.11	26.21	24.96	24.72	26.68	31.39	34.73	14.15	10.31	0.51	0.67	1.26	1.23	1.38	1.39	60:	9.	85.1	1.95	1.47	1.60	98.	88.00	2.08	2.33	2.53	3.39	5.05	2.93	3.16	2.16	ion. All Ku	ent. led in the R	
Non- Facility PE	N A	NA	0.00	NA	N.A	Y.	Z ;	K X	C Z	. AN	N.	NA	Ν	Ϋ́	V.	ΝA	۲ ;	K 2	3.47	3.24	3.28	NA	3.50	Ϋ́,	2.8 V A	Y.	NA	Z.	Y.	ζ <u>ζ</u>	N.	N.	NA	NA NA	K K	Y X	N.	4.79	cal Associat	dicare paym is not reflect	
Physi- cian Work	17.36	20.20	0.00	15.71	5.62	29.57	38.47	30.66	27.23	25.73	25.23	28.23	42.17	43.46	11,48	11.32	2.33	0.03	1.92	2.16	2.07	2.10	1.80	2.56	2 57	3.27	2.37	2.68	3.38	3.16	3.55	4.12	4.52	6.30	9.73	5.45	5.99	3.86	nerican Medi	used for Me monstration	rounding.
Description	Nasal/sinus endoscopy, surg	Nasal/sinus endoscopy, surg	Sinus surgery procedure	Removal of larynx lesion	Diagnostic incision, larynx	Removal of laryax	Removal of larynx	Partial removal of larynx	Partial removal of larger	Partial removal of Jarynx	Partial removal of larynx	Partial removal of larynx	Removal of larynx & pharynx	Reconstruct larynx & pharynx	Revision of larynx	Removal of epiglottis	Insert emergency airway	Change of windpipe arrway	Laryngoscopy with bionsy	Remove foreign body, larynx	Removal of larynx lesion	Injection into vocal cord	Laryngoscopy for aspiration	Dx laryngoscopy, newborn	Dx laryngoscopy excl no Dx laryngoscopy w/oner score	Laryngoscopy for treatment	Laryngoscopy and dilation	Laryngoscopy and dilation	Laryngoscopy w/tb removal	Laryngoscopy w/to & op scope Laryngoscopy w/hionsy	Laryngoscopy w/bx & op scope	Laryngoscopy w/exc of tumor	Larynscop w/tum exc + scope	Remove vc lesion w/scope	Remove vc lesion scope/graft	Laryngoscop w/arytenoidectom	Larynscop, remve cart + scop	Laryngoscope w/vc inj	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights reserved.	Y wature, are further to cours, not payable by intended to prease there that that the course, to the established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 88940, and 88942. The requirement requestions will only be replected in the files used for	dedicare payment. Global totals for malpractice RVUs may not sum due to rounding.
ğ	A	∢	Ç	<	¥	۷.	∢ .	< ≺	< ∢	: ∢	. ≺	<	4	∢	∢	∢	∢ •	∢ ∢	: ≺	<	A	∢	¥.	∢ •	< ∢	٠ <	¥	∢	∢ •	ং ৰ	. ∢	4	₹ .	₹	¥	٧.	∢ .	٧	codes and ed.	hed as a c udget new	Medicare payment.
3																																						-	Reserved.	establis The b	Medica
l _{e1} LdO	31293	31294	31299	31300	31320	31360	31365	31367	31370	31375	31380	31382	31390	31395	31400	31420	31500	20515	31510	31511	31512	31513	31515	31520	31526	31527	31528	31529	31530	31535	31536	31540	31541	31545	31546	31560	31561	31570			
Mal- Practico Practico	1.08 090							0.00																	0.14 0.00						0.22 000			0.26 000		1,44 010	010 971	1.04	nts	eeu Us for CPT Ar	ī
Facility PE DVII.23	10.50	1.86	0.00	1.48	3.13	5.90	6.96	78.7	7.48	9.34	6.83	10.65	13.84	20.75	14.88	21.43	14.61	15.04	9.03	10.39	12.24	21.54	23.40	0.92	5.5	18.	1.94	8.44	1.63	3,66	1.95	2.97	4.56	2.24	2.56	11.68	12.19	10.37	o. All Rigi	ness values have been e payment. treflected in the RVUs fed in the RVUs	
Non- Facility PE	NA	NA	0.00	3.35	NA	8.92	10.77	K X	Ç Z	N N	×	NA	NA	N.A	NA	NA	A .	¢ 2	Y X	N.	NA	N.	Y.	3.77	4.54 5.03	5.34	5.30	N A	Y :	K Z	N.	N.	NA	NA	NA	Y.	Y.	NA	al Associatio	icare paymer s not reflecte	
Physical clan Work	11.03	1.28	0.00	1.17	6	α.																																	g d	T Med	ding.
	-	نــ	Ö	Ξ	1.93	2.99	5.95	0.0	5.33	7.16	4.32	9.40	12.54	13.99	14.75	15.44	14.16	16.59	5.03	8.49	10.47	26.44	30.56	0 :	2.18	2.98	3.26	9.23	2.61	40.4	3.29	5,45	8.84	3.91	4.57	18.50	19,45	15.79	encan M	used for nonstra	. D.
(c) L(c)	A Ligation, upper jaw artery	A Ther fx, nasal inf turbinate	C Nasal surgery procedure 0.		Irrigation, sphenoid sinus	Exploration, maxillary sinus	Exploration, maxillary sinus	Explore sinus, remove polyps		Sphenoid sinus surgery	Exploration of frontal sinus	Exploration of frontal sinus	Removal of frontal sinus	Removal of frontal sinus	Removal of frontal sinus	Removal of frontal sinus	Removal of frontal sinus	A Geneval of frontal smus 14.39	Removal of ethmoid sinus	Removal of ethmoid sinus	Removal of ethmoid sinus	Removal of upper jaw	*	Nasal endoscopy, dx	A Nasalvimus endoscopy, dx 2.18	Nasal/sinus endoscopy, sure	Nasal/sinus endoscopy, surg		60	A Revision of chimoid sinus 4.04 A Removal of ethinoid sinus 6.04	s,			Nasal/sinus endoscopy, surg	Nasal/sinus endoscopy, surg	Nasal/sinus endoscopy, surg	Nasal/sinus endoscopy, surg	A Nasal/sinus endoscopy, surg 15.79	CP1 codes and descriptions only are copyright 2009 American Medical Association. All Rights Secured.	It values are principal for course not payable by whethers please bore and uses values have been established as coursesy to the general public and are not used for Medicare payment. ³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RUUs for CPT codes 03041 and 03042. The remired reduction will only be reflected in the files used for	Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.

į				Physi- cian	Non- Facility	Facility	Je W		,504.13			Physician	Non- Facility pr	Facility	Mal- Practice	
HCPCS	Mod	Status	Description	RVUs ^{2,3}	RVUs ²³	RVUs.3	RVUs.3.4	Global	HCPCS	Mod Status	Description	RVUs ^{2,3}	RVUs23	RVUs ^{2,3}	RVUs***	Global
		∢	Laryngoscop w/vc inj + scope	4.26	Ϋ́Z	2.41	0.28	000	31645	¥	Bronchoscopy, clear airways	3.16	4.40	1.12	0.21	000
31575		<	Diagnostic laryngoscopy	1.10	1.85	0.91	0.07	000	31646	∀	Bronchoscopy, reclear airway	2.72	4.11	86.0	61.0	000
31576		4	Laryngoscopy with biopsy	1.97	3.77	1.30	0.13	000	31656	A	Bronchoscopy, inj for x-ray	2,17	5.17	97.0	0.12	000
31577		<	Remove foreign body, larynx	2.47	3.75	1.48	0.17	000	31715	¥	Injection for bronchus x-ray	1.11	Y Y	0.30	90:0	000
31578		Ą	Removal of larynx lesion	2.84	4.38	1.74	0.18	000	31717	¥	Bronchial brush biopsy	2.12	4.22	0.74	0.15	000
31579		4	Diagnostic laryngoscopy	2.26	3.19	1.47	0.15	000	31720	¥	Clearance of airways	1.06	Ϋ́	0.31	90.0	900
31580		4	Revision of larynx	14.46	ΥN	16.93	14.1	060	31725	4	Clearance of airways	1.96	Y.	0.55	0.15	000
31582		. ≺	Revision of larvnx	22.87	NA	25.79	2.23	060	31730	٧	Intro, windpipe wire/tube	2.85	26.35	66:0	0.32	000
31584		< <	Treat larvity fracture	20.35	Ϋ́Z	18.83	1.98	060	31750	∀	Repair of windpipe	15.19	Ϋ́Z	19.54	1.70	060
31587		: «	Revision of Jarynx	15.12	NA	11.00	1.47	060	31755	V	Repair of windpipe	17.19	Ϋ́	26.75	1.68	060
31588		<	Revision of larvnx	14.62	NA	14.58	1.43	060	31760	K	Repair of windpipe	23,36	Y.	10.74	4.15	060
31590		. ∢	Reinnervate larynx	7.63	ΑN	14.84	0.74	060	31766	4	Reconstruction of windpipe	31.58	Ϋ́	15.08	5.61	060
31595		Ą	Larynx nerve surgery	8.75	ΝĀ	10.89	0.85	060	31770	Y	Repair/graft of brouchus	23.48	Y.	9.71	4.17	060
31599		Ç	Larynx surgery procedure	0.00	0.00	0.00	000	YYY	31775	A	Reconstruct bronchus	24.51	NA	10.32	4.36	060
31600		4	Incision of windnine	7.17	ΝΑ	3,04	0.87	000	31780	<	Reconstruct windpipe	19.70	Ϋ́	10.99	2.38	060
31601		: ∢	Incision of windoine	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Ϋ́Z	2.46	0.29	000	31781	*	Reconstruct windpipe	24.77	A'N	13.67	2.42	060
31603		: 4	Incision of windrine	4 14	Ϋ́Z	49	0.46	000	31785	4	Remove windpipe lesion	18.29	ΥZ	10.01	1.97	060
31605		. ∢	Incision of windnine	3 57	Z	00	0.42	000	31786	V	Remove windoine lesion	25.34	Ϋ́Z	10.57	4.50	060
31610		: ∢	Incision of windning	9 20	Y Z	906	860	060	31800	<	Repair of windpipe injury	8.10	Ϋ́	10.25	0.79	060
31613		: ⊲	Surgen/speech proofbesis	\$ 92	Y Z	7 91	0.58	060	31805	<	Renair of windnine injury	13,34	Ž	8.05	2.37	060
31617		< <	Supergrapheen prosucess Duncture (clear mindaine	200	18	0.35	80.0	000	31820	. ∢	Closure of windpine lesion	4.58	6.54	3.89	0.49	060
31012		۲ <	Panaleur/creat waterpipe	16.0	A M	78.9	0.00	080	31825	. ∢	Renair of windnine defect	86.9	8.45	5.44	0.72	060
31613		۲ -	Repair waterple opening	50:0	V	02.01	100	000	31830	(∢	Revise windnine cor	4 54	6.57	4 14	0.52	060
31014		۲ -	Viscolization of mindains	900	85 6	1 28	0.0	000	31899	t C	Airways surgical procedure	0.00	000	000	000	λλλ
31630		τ <	Visualization of whilipipe	1.40	5 37	0.40	100	222	32035) ⊲	Exploration of chest	11 20	AZ	6.86	195	060
21020		< <	De bronchoromanius dunch	27.6	4 96	20.7	0.10	000	32036	. ∢	Exploration of chest	12.21	Ϋ́	7.22	2.16	060
31622		ς <	Dy bronchoscope much	2 6	32.5	100	610	000	32095	: ∢	Bionsy through chest wall	10.06	Y.	5.82	1.78	060
2162		ξ <	Dy bronchoscome/lavace	200.7	2.70	70.	61.0	000	32100	₹ 4	Exploration/hionsy of chest	16.08	Y Z	7.90	2.86	060
21625		(⊲	Pronchoscopy w/hionsy(s)	3.36	5.04	<u>×</u>	0.24	000	32110	. ∢	Explore/repair chest	25.15	Y Z	11.48	4.23	060
31679		< ⊲	Bronchoccopy fine by each	3.80	621	1 28	0.23	000	32120	< <	Re-exploration of chest	14.27	NA	7.59	2.55	060
31670		(<	Bronchoscopy/ mag uv, caca Bronchoscopy/needle by each	4 09	10.54	3 2	0.26	000	32124	. 4	Explore chest free adhesions	15.33	Y.	8,00	2.76	060
31630		(∢	Bronchoscopy dilate/fy repr	8	NA	146	0.35	000	32140	¥	Removal of lung lesion(s)	16.54	Y'Z	8.50	3.14	060
31631		: •	Bronchocomy dilate w/stent	4 36	Ą	165	0.41	000	32141	4	Remove/treat lung lesions	27.10	Y.	11.54	4.85	060
31632		: ∢	Bronchoscony/lung bx. add/E1	1.03	0.82	0.30	0.06	222	32150	Y	Removal of lung lesion(s)	16.70	Ϋ́	8.47	2.97	060
31633		: ∢	Bronchoscopy/needle bx addE1	1.32	0.95	0.38	80:0	777	32151	A	Remove lung foreign body	16.82	NA	8.19	2.99	060
31635		₹ ₹	Bronchoscopy w/fb removal	3.67	4.92	1.30	0.29	000	32160	¥	Open chest heart massage	13.02	Y.	99.9	2.26	060
31636		Α.	Bronchoscopy, bronch stents	4.30	Ν	1.51	0.41	000	32200	A	Drain, open, lung lesion	18.48	Υ	86.6	3.28	060
31637		¥	Bronchoscopy, stent add-on	1.58	NA	0.42	60.0	222	32201	A	Drain, percut, lung lesion	3.99	14.43	1.21	0.29	000
31638		¥	Bronchoscopy, revise stent	4.88	NA	1.77	0.46	000	32215	¥	Treat chest lining	12.93	ΝA	7.17	2.27	060
31640		¥,	Bronchoscopy w/tumor excise	4.93	ΥN	1.80	0.44	000	32220	¥	Release of lung	26.41	ΥN	13.43	4.74	060
31641		· •	Bronchoscopy, treat blockage	5.02	NA	1,78	0.41	000	32225	4	Partial release of lung	16.63	Š	8.38	2.96	060
31643		¥	Diag bronchoscope/catheter	3,49	Ϋ́N	1.15	0.22	000	32310	∀	Removal of chest hing	15.16	NA	7.92	2.73	060
	CPT cod	des and	* CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	cal Associat	ion. All Rig	hts		-	CPT codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Mec	lical Associal	tion. All Righ	23	
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~	if values	s are ref.	2 If values are reflected for codes not payable by Medicare, please note that	are, please not	e that these v	these values have been	xec			If values are re	If values are reflected for codes not payable by Medicare, please note that these values have been	licare, please no	te that these	values have b	cn	
O.v.	stablishe The bud	edasac loetnem	established as a courtesy to the general public and are not used for Medicare payment. The badeat matter lity reduction from the chiromentic demonstration is not reflected.	ot used for Me	dicare paym	ent. ed in the RV	payment. reflected in the RVI is for CPT		ຍ	Stabiished as a The budget ne	established as a courtesy to the general public and are not used for medicare payment. The budget neutrality reduction from the chiromactic demonstration is not reflected in the RVUs for CPT.	not used for M	edicare payur is not reflec	rent. ted in the RV	Js for CPT	
ن	odes 989	uger ueu. 940, 989	the bunget beat and (1907) to continuous and the control action will only be reflect	will only be	reflected in t	ed in the files used for	lfor		٥	odes 98940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	ion will only be	reflected in	the files used	or	
4	fedicare	Medicare payment	at.	;					~ •	Medicare payment	ont.	:				
,	Global t	totals for	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.						Giobal totals t	Global lotals for maipractice K VUS may not sum due to rounding.	e to rounding.				

Physi- Pacina Cian Fig. Work			- a	Non- Facility PE	Facility	Mai- Practice	l _{t'1} LdD			Physi- clan Work	Non- Facility PE	Facility PE	Mai- Practice	
RVUs23 RVUs23 RVUs23 RVUs234 G	Description RVUs ²³ RVUs ²³ RVUs ^{23,4} C	RVUs ²³ RVUs ²³ RVUs ^{23,4} C	RVUs ^{2,3} RVUs ^{2,3,4} C	* RVUs ^{2,3,4}	•	Giobal	HCPCS Mod	Status	Description	RVUs.	RVUs.	RVUs.	RVUs""	Global
4.77	27.04 NA 13.13 4.77	NA 13.13 4.77	13.13 4.77	4.77		060	32662	K	I horacoscopy, surgical	14.91	4	(5)	2.03	26
1.96 0.53 0.13	1.76 1.96 0.53 0.13	1.96 0.53 0.13	0.53 0.13	0.13		000	32663	٧	Thoracoscopy, surgical	24.56	Y Z	10.56	4.35	36
Onen bionsy chest lining 8.89 NA 5.37 1.53	8.89 NA 5.37 1.53	NA 5.37 1.53	5.37 1.53	1.53		060	32664	4	Thoracoscopy, surgical	14.22	Ϋ́	68'9	2.53	060
Bionsy, June or mediastinum 1.93 0.58 0.58 0.14	1.93 0.58 0.58 0.14	0.58 0.58 0.14	0.58 0.14	0.14		000	32665	4	Thoracoscopy, surgical	21.45	٧Z	10.93	3.47	060
Punchire/clear lung 2.18 NA 0.66 0.17	2.18 NA 0.66 0.17	NA 0.66 0.17	0.66	0.17		000	32800	<	Repair lung hernia	15.59	NA	6.32	68.0	060
niration 1.54 2.26 0.48 0.11	niration 1.54 2.26 0.48 0.11	2.26 0.48 0.11	0.48 0.11	0.11		000	32810	4	Close chest after drainage	14.83	ΥN	7.55	2.64	060
2.19 2.70 1.01 0.16	2.19 2.70 1.01 0.16	2.70 1.01 0.16	0.16	0.16		000	32815	<	Close bronchial fistula	49.79	Ϋ́	20.68	8.99	060
27.17 NA 12.34 4.81	27.17 NA 12.34 4.81	NA 12.34 4.81	12.34 4.81	4.81		060	32820	4	Reconstruct injured chest	22.33	NA	10.69	3.97	060
ctomy 56.37 NA 19.00 3.21	56.37 NA 19.00 3.21	NA 19.00 3.21	19.00 3.21	3.21		060	32851	<	Lung transplant, single	40.94	Ϋ́Z	22.74	7.33	060
63.60 NA 24.43 11.30	63.60 NA 24.43 11.30	NA 24.43 11.30	24.43 11.30	11.30		060	32852	4	Lung transplant with bypass	44.65	Ϋ́	25.63	7.93	060
flung 25.71 NA 11.62	flung 25.71 NA 11.62 4.58	NA 11.62 4.58	11.62 4.58	4.58		060	32853	٧	Lung transplant, double	50.11	NA	25.66	10.6	060
27.28 NA 12.63 4.86	27.28 NA 12.63 4.86	NA 12.63 4.86	12.63 4.86	4.86		060	32854	<	Lung transplant with bypass	53.88	ΝĀ	29.20	69.63	060
nv 25.30 NA 10.94 4.48	25.30 NA 10.94 4.48	NA 10.94 4,48	10.94 4.48	4.48		060	32855	ပ	Prepare donor lung, single	00:0	0.00	0.00	00:0	XXX
v 42.80 NA 16.45 7.69	v 42.80 NA 16.45 7.69	NA 16.45 7.69	16.45 7.69	69.2		060	32856	၁	Prepare donor lung, double	0.00	0.00	0.00	00'0	XXX
nonectomy 42.83 NA 17.34 7.66	42.83 NA 17.34 7.66	NA 17.34 7.66	17.34 7,66	7.66		060	32900	<	Removal of rib(s)	23.69	Ϋ́Z	11.00	4.16	060
25.09 NA 11.63 4.46	25.09 NA 11.63 4.46	NA 1163 446	11 63 446	4 46		060	32905	4	Revise & repair chest wall	23.17	Ϋ́	10,09	4.12	060
24.48 NA 11.65 4.38	24.48 NA 11.65 4.38	NA 11.65 4.38	11.65 4.38	4.38		060	32906	<	Revise & repair chest wall	29.18	Ϋ́Z	11.92	5.19	060
4.68 NA 1.50 0.82	4.68 NA 1.50 0.82	NA 1.50 0.82	1.50 0.82	0.82		ZZZ	32940	<	Revision of lung	21.22	NA	9.50	3.77	060
31.61 NA 13.53 5.64	31.61 NA 13.53 5.64	NA 13.53 5.64	13.53 5.64	5.64		060	32960	4	Therapeutic pneumothorax	1.84	1.89	0.74	0.33	000
best 36.41 NA 15.16 6.39	best 36.41 NA 15.16 6.39	NA 15.16 6.39	15.16 6.39	6.39		060	32997	<	Total lung lavage	7.31	Ϋ́	2.12	0.73	000
30.22 NA 13.30 5.39	30.22 NA 13.30 5.39	NA 13.30 5.39	13.30 5.39	5.39		060	32998	٧	Perq rf ablate tx, pul tumor	5.68	60.11	1.83	0.46	000
Insert pleural cath 4.17 15.32 1.58 0.52	4.17 15.32 1.58 0.52	15.32 1.58 0.52	1.58 0.52	0.52		000	32999	ပ	Chest surgery procedure	0.00	00.0	0.00	0.00	λλλ
Insertion of chest tube 3.29 NA 1.10 0.38	ube 3.29 NA 1.10 0.38	NA 1.10 0.38	1.10 0.38	0.38		000	33010	<	Drainage of heart sac	2.24	ΑN	0.72	0.18	000
Treat lung lining chemically 2.19 5.21 0.69 0.28	2,19 5.21 0.69 0.28	5.21 0.69 0.28	0.69 0.28	0.28		000	33011	4	Repeat drainage of heart sac	2.24	NA NA	0.75	0.16	000
Thoracoscopy, diagnostic 5.45 NA 2.31 0.94	5.45 NA 2.31 0.94	NA 2.31 0.94	2.31 0.94	0.94		000	33015	٧	Incision of heart sac	8.44	ΥZ	4.14	1.26	060
Thoracoscopy, diagnostic 5.95 NA 2.48 1.02	5.95 NA 2.48 1.02	NA 2.48 1.02	2.48 1.02	1.02		000	33020	4	Incision of heart sac	14.87	Ϋ́Z	7.18	2.65	060
Thoracoscopy, diagnostic 7.80 NA 3.03 1.48	7.80 NA 3.03 1.48	NA 3.03 1.48	3.03 1.48	1.48		000	33025	<	Incision of heart sac	13.65	Ν	6.54	2.47	060
Thoracoscopy, diagnostic 8.77 NA 3.27 1.56	8.77 NA 3.27 1.56	NA 3.27 1.56	3.27 1.56	1.56		000	33030	٧	Partial removal of heart sac	22.27	NA	10.15	4.02	060
Thoracoscopy, diagnostic 6.92 NA 2.71 1.23	6.92 NA 2.71 1.23	NA 2.71 1.23	2.71 1.23	1.23		000	33031	٧	Partial removal of heart sac	25.30	ΝA	10.73	4.63	060
8.39 NA 3.29 1.45	8.39 NA 3.29 1.45	NA 3.29 1.45	3.29 1.45	1.45		000	33050	٧	Removal of heart sac lesion	16.85	Ϋ́	8.32	2.99	060
10.77 NA 6.01 1.88	10.77 NA 6.01 1.88	NA 6.01 1.88	6.01 1.88	1.88		060	33120	٧	Removal of heart lesion	27.33	ΑN	11.89	4.96	060
18.70 NA 8.86 3.25	18.70 NA 8.86 3.25	NA 8.86 3.25	8.86 3.25	3.25		060	33130	<	Removal of heart lesion	24.05	ΥN	17.56	4.57	060
29.00 NA 12.71 5.10	29.00 NA 12.71 5.10	NA 12.71 5.10	12.71 5.10	5.10		060	33140	∢	Heart revascularize (tmr)	28.26	NA	11.32	5.37	060
18.09 NA 8.43 3.14	18.09 NA 8.43 3.14	NA 8.43 3.14	8,43 3.14	3.14		060	33141	<	Heart unr w/other procedure	2.54	NA V	0.83	0.46	777
20,44 NA 9,29 3.52	20,44 NA 9,29 3.52	NA 9.29 3.52	9.29 3.52	3.52		060	33202	∢	Insert epicard eltrd, open	13.15	Ϋ́Z	6.25	2.38	060
16.09 NA 8.02 2.83	16.09 NA 8.02 2.83	NA 8.02 2.83	8.02 2.83	2.83		060	33203	٧	Insert epicard eltrd, endo	13.92	ΝA	6.14	2.43	060
13.18 NA 6.89 2.28	13.18 NA 6.89 2.28	NA 6.89 2.28	6.89 2.28	2.28		060	33206	4	Insertion of heart pacemaker	7.31	ΝA	3.78	1.19	060
200 AN AUC	200 AN AUC	86 C 98 9 VIV	6.66 2.38	3.78		000	33207	: <	Insertion of heart pacemaker	8 00	YZ	3.8	131	060
100 117 VIN 2711	100 117 VIN 2711	2000 113 VIN	200	100		000	33300		Incartion of heart nocemptor	6 73	Z	4.04	1.42	000
11.05 NA 0.11 2.07	11.05 NA 0.11 2.07	NA 0.11 2.07	0.11 2.0/	70.7		080	33208	< ∙	discuson of near pacemaker	0.12	ć ;	; ·	700	200
NA 6.42 2.12	11.86 NA 6.42 2.12	NA 6.42 2.12	6.42 2.12	2.12		060	33210	<	Insertion of heart electrode	3.30	ď	01.1	0.25	3 :
3.36	17.69 NA 8.12 3.36	NA 8.12 3.36	A 8.12 3.36	3.36		060	33211	∢	Insertion of heart electrode	3.39	Ϋ́	Ξ.	036	000
13.27 NA 6.60 2.36	13.27 NA 6.60 2.36	NA 6.60 2.36	2.36	2.36		060	33212	₹	Insertion of pulse generator	5.51	Ϋ́	2.75	0.00	060
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I CUCCS AIRL GESCHPRINGS OURY GIV COPPRING COOR CHRISTING ROCKELL COSTOCIATORS. COE CAGAILS	מת שבסרוונוווטעס טעוד פור בסנין אונינוועני בינים המוניוויסנו ואנימנויסנו הססינימנויטע. היע ניטנונו	יווים אין אין יוויטטטעמן הפטעמעני דעט ואקעויי	ARREL TOSOVIATION. TRE INGRIS	ander our referre	-		Beserved							

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Trigules are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiroptractic demonstration is not reflected in the RVUs for CPT codes 98940, 9841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

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The first last are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT receives 98940, 98041, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for majtractice R VUs may not sum due to rounding.

			Physi- cian	Non- Facility	Facility	K Si		;				Physi- cian	Non- Facility	Facility	1 2 2 3	
CPT ¹³ / HCPCS N	Mod Statu	Description	Work RVUs ^{2,3}	PE RVUs ^{2,3}	PE RVUs ^{2,3}	Practice RVUs ^{2 3.4}	Global	CPT -/	Mod Status	_	Description	Work RVUs ^{2, 3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs 23.	Global
	٧	insertion of pulse generator	6.36	NA NA	3.02	1.04	060	33320	٩	Re	Repair major blood vessel(s)	18.46	Ν	8.26	3.22	060
33214	٧	Upgrade of pacemaker system	7.78	NA	3.96	1.25	060	33321	۹.	Rel	Repair major vessel	20.71	Ϋ́Z	6.87	Ξ:	060
33215	<	, 224,	4.89	NA	2.50	0.80	060	33322	•	Rel	Repair major blood vessel(s)	24.30	ΥN	10.97	4.44	060
33216	∢		5.81	A.	3.25	0.94	060	33330	•	suj '	nsert major vessel graft	25.17	Ϋ́	12.64	4.78	060
33217	٧		5.78	Y.	3.25	0.95	060	33332	٩	lns	nsert major vessel graft	24.46	Ϋ́	10.53	4.65	060
33218	<	_	5.97	Ϋ́	3.44	86.0	060	33335	•1.	sur	nsert major vessel graft	33.79	Ϋ́Z	14.24	6.20	060
3321F	-		0.00	0.00	00.0	0.00	XXX	33400	•	Rel	Repair of aortic valve	41.37	NA	16.42	7.44	060
33220	• ∢		6.05	Z	3.50	86.0	060	33401	۹.	Va	/alvuloplasty, open	24.41	ΝA	10.64	4.05	060
33222	∶ <		5.01	Y.	3.34	0.83	060	33403	•	Va	/alvuloplasty, w/cp bypass	25.39	ΝA	11.83	4.82	060
33223	∶ ∢		6.49	X	3.48	1.07	060	33404	٩	Pre	Prepare heart-aorta conduit	31.25	Y'N	13.24	5.55	060
33224	. ⋖		9.04	NA A	3.35	0.81	000	33405	4.	Re	Replacement of aortic valve	41.19	ΝA	16.90	7.51	060
33225	<		8.33	Y.Z	2.80	0.63	777	33406	٩	Rel	Replacement of aortic valve	52.55	NA	20.51	89.6	060
33226	₹		89.8	N.A.	3.23	0.78	000	33410	q,	Rel	Replacement of aortic valve	46.28	NA	18.56	8.45	060
3322F	:	. ,	0.00	0.00	0.00	0.00	XXX	33411	•	Re	Replacement of aortic valve	61.94	NA	23.64	11.31	060
11711	. ∢		3.33	X.	2.36	0.54	060	33412	٩	Rej	Replacement of aortic valve	43.77	ΑN	18.03	8.31	060
11734	: ∢		7.85	Y	3.94	1.28	060	33413	•	Rei	Replacement of aortic valve	59.74	NA	21.70	10.62	060
11734	: ∢		9 93	Y.	5.28	164	060	33414	•	Res	Repair of aortic valve	39.29	Ϋ́	15.14	86.9	060
33736	; ∢		12.64	Y.	7.05	2.40	060	33415	•	Re	tevision, subvalvular tissue	37.19	NA	14.74	6.02	060
11717	. ∢		13.75	. Y	6.56	2.44	060	33416	•	Re	Revise ventricle muscle	36.43	Ϋ́	15.36	6.65	060
13738	: ∢		15.28	Ž	8.23	2.75	060	33417	•	Re	Repair of aortic valve	29.17	٧Z	13.10	5.32	060
13240	. ∢		7.61	Y.	3.56	1,23	060	33420	•1.	Re	Revision of mitral valve	25.67	ΝA	11.89	2.59	060
33241	. ∢		3.26	NA V	2.11	0.53	060	33422	•	Re	Revision of mitral valve	19.61	ΥV	12.57	5.62	060
33243	: <	_	23.42	Y Z	10.79	4.19	060	33425	₹.	Re	Repair of mitral valve	49.83	Ν	19.43	9.10	060
33244	< ▼		13.84	NA	6.73	2.28	060	33426	•	Rel	Repair of mitral valve	43.15	NA	17.61	7.85	060
33249	<	_	15.02	Ϋ́	6.81	2.42	060	33427	۹.	Re	Repair of mittal valve	44.70	NA	17.48	8.13	060
33250	: ▼	_	25.78	NA VA	11.09	4.90	. 060	33430	V	Rel	Replacement of mitral valve	50.75	NA	20.68	9.28	060
33251	< <	. •	28.80	NA	12.77	5.30	060	33460	•	Re	Revision of tricuspid valve	44.62	NA	29.10	8.48	060
33254	₹	•	23.58	NA	10.89	4.48	060	33463	4	\A	/alvuloplasty, tricuspid	56.95	NA	21.67	10.45	060
33255	<	_	28.91	NA	12.47	5.49	060	33464	٩	. Va	/alvuloplasty, tricuspid	44.49	ΥN	18.08	8.02	060
33256	<	`	34.77	NA V	14.36	6.61	060	33465	•	Re	Replace tricuspid valve	50.59	NA	19.57	9.29	060
33257	∢	~	9.63	Ϋ́Z	5.25	1.74	222	33468	٩	Re	Revision of tricuspid valve	32.82	NA	13.32	6.23	060
33258	٧	*	11.00	N'A	5.74	1.97	777	33470	•	Re	Revision of pulmonary valve	21.32	NA	9.42	3.79	060
33259	¥	_	14.14	×	7.44	2.56	777	33471	٩	, va	/alvotomy, pulmonary valve	22.83	Ν	10.92	1.22	060
33261	Y	Ablate heart dysrhythm focus	28.80	NA A	12.03	5.47	060	33472	۹,	Re	Revision of pulmonary valve	22.90	ΝĄ	10.45	1.23	060
33265	¥	Ablate atria, fmtd, endo	23.58	Ϋ́	10.76	4.26	060	33474	•	Re	Revision of pulmonary valve	39.27	Ϋ́	15.16	7.46	060
33266	∀	Ablate atria, x10sv, endo	32.91	NA	13.78	6.01	060	33475	۹.	Re	Replacement, pulmonary valve	42.27	Ϋ́	16.42	8.03	060
33282	A		4.70	Ϋ́Z	2.96	0.76	060	33476	۹.	Re	Revision of heart chamber	26.41	NA	11.76	5.02	060
33284	¥		3.04	ZA	2.41	0.49	060	33478	•	Re	Revision of heart chamber	27.38	NA	12.06	5.20	060
33300	¥	-	44.89	YZ.	16.98	8.12	060	33496	•	Rej	Repair, prosth valve clot	17.62	ΝA	12.97	5.28	060
33305	٧	Repair of heart wound	76.85	NA	27.04	13.95	060	33500	₹.	Rej	tepair heart vessel fistula	27.82	NA	11.72	5.28	060
33310	*	_	20.22	Y.	9.40	3.59	060	33501	•	Rel	Repair heart vessel fistula	19.43	NA	8.85	3.69	060
33315	<	Exploratory heart surgery	26.05	NA	11.36	4.76	060	33502	٩	Ö	Coronary artery correction	21.69	ΝA	10.29	4.12	060
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The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT receives 98940, 9844, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R VUs may not sum due to rounding.

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The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Global	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	777	060	060	060	060	060	060	060	960	060							
Mal- Practice RVIIs ^{2,3,4}	5.32	5.58	6.03	1979	6.95	6.37	1.97	2.05	5.89	6.51	6.59	3.59	1.68	6.74	6.22	5.15	5.38	4.82	5.52	4.90	7.04	6.84	5.47	4.19	4.59	3.97	00.9	3.72	1.20	3.63	4.47	0.43	6.93	2.17	5.99	1.76	1.85	1.82	2.28	/0/	2.35	ıts	Ę.		Us for CPT	101		
Facility PE RVIIs ^{2,3}	11.60	21.27	12.45	23.33	13.09	13.51	15.51	16.06	14.49	22.75	12.73	69.6	13.58	13.36	14.14	11.70	12.46	11.50	11.51	10.97	14.13	14.37	12.54	10.26	01.1	10.04	14.81	9.76	10.32	17.18	10.32	2 62	16.60	16.10	13.58	14.73	15.64	14.67	18.05	15.07	28.22	m. All Righ	lues have be	nt.	d in the RVI	e tiles used		
Non- Facility PE RVIA ^{2, 3}	Ϋ́	Y Z	¥ Z	NA.	NA	ΝĄ	NA	Y Z	ΑN	NA	NA	NA	ΝA	NA	NA	NA	ΝĄ	Ϋ́Α	ΑN	NA	NA	ΝĄ	Ϋ́	NA	Y'A	NA V	Y.	V.	Y.	K 2	ζ Z	Z Z	N.	NA	NA	NA	NA	Y Z	¥Z;	K Z	ΥN	al Associatio	that these va	icare paymer	s not reflecte	mected in the		
Physican cian Work PVIIs ^{2,3}	27.98	29.37	31.75	34.77	36.58	35.87	36.87	38.37	32.16	34.29	34.67	20.20	31.38	35.49	37.49	27.11	30.28	27.13	29.05	27.55	37.04	36.01	28.80	22.04	24.16	22.34	22.06	22.44	22.44	22.44	25.14	8.00	39.02	40.58	31.54	32.83	34.53	33.95	42.62	43.15	43.85	merican Medic	atou assafu a	t used for Med	emonstration i	will only be r	rounding.	.0
Description	Revision of heart veins	Renair heart sentim defects	Renair of heart defects	Repair of heart defects	Repair of heart chambers	Close mult vsd	Close mult vsd w/resection	CI mult vsd w/rem pul band	Repair heart septum defect	Repair heart septum defect	Repair heart septum defect	Reinforce pulmonary artery	Repair of heart defects	Repair of heart defects	Repair of heart defects	Repair of heart defects	Repair of heart defects	Repair of heart defect	Repair of beart defect	Repair venous anomaly	Repair pul venous stenosis	Repair heart-vein defect(s)	Repair heart-vein defect	Revision of heart chamber	Revision of heart chamber	Revision of heart chamber	Major vessel shunt	Major vessel shunt	Major vessel shunt	Major vessel shunt & graft	Major vessel shunt	Cayomilmonary shinting	Repair great vessels defect	Repair great vessols defect	Repair great vessels defect	Repair great vessels defect	Repair great vessels defect	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	eserved. If values are reflected for codes not navable by Medicare abase note that these values have been	It values are reflected for cooles and paging by including process from the payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the tites used for Medicare navinent	Global totals for majoractice RVUs may not sum due to rounding					
j	on v	(⊲	: ⊲	: ∢	< <	٨	٧	4	4	4	٧	¥	٧	¥	∢	٧	٧	٧	∢	¥	٧	٧	٧	Ą	Ą	Ą	٧	∢ .	∢ .	۷ ۰	< ∢	: 4	: ∢	¥	A	٧	¥	4	4	¥	4	odes and o	d. ar ana mafi	sed as a co	dget neut	codes 98940, 9894	totals for	
3																																										' CPT o	Reserved	establish	The bu	Nedicar	4 Global	
(chTq2)	13645	33647	09988	33665	33670	33675	33676	33677	33681	33684	33688	33690	33692	33694	33697	33702	33710	33720	33722	33724	33726	33730	33732	33735	33736	33737	33750	33755	33762	33764	13767	13768	33770	33771	33774	33775	33776	33777	33778	33779	33780							
Mai- Practice Practice					5.57 090																						8.82 090				5.16 080							6.35 090			5,35 090	s	,		reflected in the RVUs for CPT).		
acility PE P				3.64	181	0.10	14.65	15.95	99:	40.	18.97	.03	81	09	3.44	00	14	99	24	00	29	.05	38	17.96	.38	00	.78	.28	.50	8 ;	#.c	6.00	3 8	.21	13.06	13.61	13.81	4.13	15.11	19.55	12.39	All Rights	mood every resident	s ilave oce	the RVU	es used fo		
	_																																						15	<u>~</u>	2	octation.	order o	rese value payment.	effected in	d in the fi		
Non- Facility PE	Š	X X	2 2	2 2	X	X	Z	Z	Z	Z	Z	Z	NA	NA	X	0.0	NA	NA	NA	00.0	NA	AZ.	NA	NA	NA	0.00	ΝA	Ϋ́Z	NA	0.0	K 2	2 2	NAN	×	NA	NA	N.	ΝA	NA	Χ×	XX	edical Ass	le sedie	Medicare	on is not r	e reflecte		
Physical clan Work	22.70	67.77	10.25	37.80	31.35	0.31	34.87	38.34	43.87	45.26	47.97	49.65	3.61	7.93	10.49	0.00	12.59	14.14	16.08	0.00	10.13	33.64	39.77	44.64	48.32	0.00	48.08	56.93	53.96	0.00	4.44	30.13	31.77	31.72	31.24	35.49	36.49	35,76	38.96	48.60	29.50	9 American M	To the second	ncare, piease r e not used for l	ic demonstrati	tion will only l	o to rounding	Smormal OLD
	_ `	Coronary arrery grant	Coronary ancily grant	Denois ortens translocation	Repair art intramiral	Endoscopic vein harvest	CABG, vein, single	CABG, vein, two	CABG, vein, three	CABG, vein, four	CABG, vein, five	Cabe, yein, six or more	CABG, artery-vem, single	CABG, artery-vein, two	CABG, artery-vein, three	Neg scrn dep symp by deptool	CABG, artery-vein, four	CABG, artery-vein, five	Cabe, art-vein, six or more	No sig dep symp by dep tool	Coronary artery, bypass/reop	CABG, arterial, single	CABG, arterial, two	CABG, arterial, three	Cabg, arterial, four or more	Mild-mod dep symp by deptool	Removal of heart lesion	Repair of heart damage	Restore/remodel, ventricle	Clin sig dep sym by dep tool	Open coronary endarterectomy	Closure of vaive	Anastomosis/artenyaorta	Renair anomaly w/conduit	Repair by enlargement	Repair double ventricle	Repair double ventricle	Repair, modified fontan	Repair single ventricle	Repair single ventricle	Repair heart septum defect	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	w . C	" If values are reflected for codes not payable by Medicare, prease note that mess values established as a courtesy to the general public and are not used for Medicare payment	The budget neutrality reduction from the chiropractic demonstration is not	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment. • Clobal totals for majoractics DVI is may not sum due to rounding	for inappractice is a contrary time ourse
	Status	۷,	۲ .	< <	₹ 4	: ∢	<	≺	<	; ∢	<	<	<	٧	¥	-	٧	٧	¥	-	٧	¥	¥	Y	¥	_	A	¥	¥	-	۷٠	< •	< 4	< ∢	. ≺	∀	٧	∢	¥	A	¥	T codes an	Reserved.	alues are	budget no	s 98940, s	Medicare payment	Day totate
	S:									_					_	-				,.	_	_										_								_			Rese	· If v	The	code	Med.	3
CPT ^{1,3} /	HCPC	33503	23204	33506	33507	33508	33510	33511	33512	33513	33514	33516	33517	33518	33519	3351F	33521	33522	33523	3352F	33530	33533	33534	33535	33536	3353F	33542	33545	33548	3354F	33572	33600	20066	33608	33610	33611	33612	33615	33617	33619	33641							

Reserved.

The states are reflected for codes not payable by Medicare, please note that these values have been established as a courtesty to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT rocks 98940, 19840, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

It whites are reflected for codes not payable by Medicare, please note that these values have been scrabblished as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 9940, 9940, 9940.

Medicare payment.

* Global lorals for malpractice RVUs may not sum due to rounding.

4	060	060	XXX	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	260	060	000	060	060	060	060	060	060	060	060	777	060	060	060	060	060	060	060						
Mal- Practice	4.13	4.96	0.00	2.71	5.11	3.03	2.44	5.67	2.29	2.84	2.29	1.47	4.47	6.52	4.38	5.66	3.16	3.02	4.78	5.08	130	3.50	27.0	465	4.57	5.14	2.98	3.45	3.71	4.10	4.26	1.4.	1.0.1	2.84	4.86	4.59	4.27	3.45	5.43	5.65	ghts	peen	101- 6- CDT	VCs for CP1 d for		
Facility PE PVIIts ^{2,3}	9.24	9.23	0.00	6.82	15.44	9,41	8.36	11.89	6.32	7.79	6.42	8.22	10.97	15.48	10.73	6.52	10.58	7.78	11.29	9.50	55.55	67.7	6.83	10.74	10.93	11.78	7.49	80.8	8.41	9.14	9.41	9.12	10.7	7.11	10.78	9.85	9.43	7.78	9.93	12.39	tion, All Ri	values have	bent.	ted in the K the files use		
Non- Facility PE PVI 12 3	N N	N.	0.00	Y.	NA	NA	NA	N.	NA	NA	Ϋ́	NA	Ϋ́	Ν	X :	ΑN	V.	Š.	Ž:	¥:	Ž,	Z ž	ζ Z	Y V	X X	X.	N A	NA	NA	NA	Z ;	۷ ×	۲ ×	C Z	AN	Y.	NA	ΝΑ	NA	NA	ical Associa	e that these	edicare payer	is not retiec reflected in 1		
Physical clan Work	23.61	27.53	000	15.01	31.58	18.72	15.05	29.85	13.33	16.84	13.76	10.85	24.50	36.47	26.54	15.22	21.08	17.94	25.50	28.15	51.83	0,000	16.00	24.50	25.72	29.93	17.06	19,53	21.27	23.52	24.52	23.52	5.25	75.02	27.61	26.10	24.53	19.78	30.11	32.22	nerican Med	e. please not	used for Me	emonstration will only be	` :	rounding.
	Repair defect of arrery	Repair artery minimine, kinee	Pt has doed immin to hen	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Kepair blood vessel lesion	Repair blood vessel fasion	Densit blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Repair blood vessel lesion	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechange of artery Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	Rechanneling of artery	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. If values are reflected for codes not payable by Medicare. please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	I he budget neutratity reduction from the chiropractic demonstration is not reflected in the KVUS for CPT, codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	et.	CHODAL IOIAIS FOR INAUPTACHEE K V US MAY NOT SUM QUE TO FOUNDING.
	Sumus A	; ∢		. «	∢	K	٧	¥	٧	4	A	Υ	V	٧	¥ ·	∢	¥	K	٧	∢ .	∢ ⋅	∢ •	* •	< <	< ∢		₹ ₹	V	٧	¥	V.	∢ .	₹ ₹	€∢	: ∢	: ∢	<	<	∢	∢	codes and	ed. ues are ref	shed as a c	ndget neu 18940, 989	Medicare payment	II totais io
l _{c1} LdO	35151	35152	3515E	35180	35182	35184	35188	35189	35190	35201	35206	35207	35211	35216	35221	35226	35231	35236	35241	35246	33231	33230	19755	35371	35276	35281	35286	35301	35302	35303	35304	35305	35306	35371	35331	35341	35351	35355	35361	35363	CPT	Reserved	establis	the b	Medica	BOIO
į	777	000	777	000	060	777	060	060	060	000	000	060	XXX	XXX	XXX	060	060	060	060	060	060	060	060	060	060	060	060	060	XXX	060	060	XXX	960	o XXX	060	060	XXX	060	060	XXX						
Mai- Practice	80AY	1.17	0.83	49	2.08	990	6.33	6.83	6.83	5.09	0.94	2.70	0.00	000	0.00	3.64	3.58	3.46	3.19	3.97	3.93	6.5	5.03	2.00	623	8.92	6.37	7.53	00'0	4.24	5.25	0.00	3.50	000	4 60	5.62	00:0	3.65	4.38	0.00	hts	een		Os for CP		
Facility PE	1 22	1 00	1 43	2 93	5.56	1.28	11.28	12.03	12.03	3.89	1.82	6.75	00'0	0.00	0.00	8.89	10.98	13.28	7.69	9.47	9.58	10.00	46.5	16.43	12.23	17.93	13.60	15.65	00.0	12.37	14.83	0.00	11.88	10.61	10.43	12.15	000	8.31	9.84	0.00	ion. All Rig	these values have been	ent.	t reflected un the RVUs ted in the files used for		
Non- Facility PE	NA NA	Y Y	V.	NA N	AN	NA	NA	NA	NA	NA	NA	NA	0.00	0.00	0.00	NA	NA.	NA	ΥN	NA	Y :	ΨZ:	NA	4 2	C V	Y X	Ϋ́	Ϋ́	00.0	NA	NA	0.00	ď:	AN O	AN AN	Z X	0.00	Ϋ́	NA	0.00	ical Associal	e that these	dicare paym	is not reflec reflected in 1		
Physi- cian Work	KVU8	4.1.4 4.7.4	4 70	0.74	12.72	4.12	35.10	37.85	37.85	11.98	5.34	16.77	00.00	0.00	00.0	20.70	22.12	19.18	18.50	23.10	22.09	25.62	17.94	13.37	15.35	50.81	36.37	43.49	0.00	26.17	32.44	0.00	31,41	97:79	36.30	32.44	0.00	20.83	25.03	00.0	merican Med	nleace not	t used for Me	emonstration will only be		rounding.
į	55	A Years for endomosth femori			A Endovase extend prosth, init			_	A Open aortofemor prosth repr	A Xpose for endoprosth, iliac	A Xpose, endoprosth, brachial	A Endovase iliac repr w/graft	I HIV unsure baby of HIV+moms			 A Repair defect of artery 				 Repair artery rupture, arm 			A Repair defect of arm artery		A Repair artery rupture, dorta				I Doc th semg-rafts interped	A Repair defect of artery	 A Repair artery rupture, spleen 	I Chlmyd/gonrh 1sts doed done	A Repair detect of artery	A Repair artery rupture, belly	A Demait defect of attent		Hen B script doed as done	A Repair defect of artery		I Hep C scring doed as done	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. 2 if values are referred for codes not navable by Medicare please note that	established as a courtesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CP1 codes 08040 and 08047. The required reduction will only be reflected in the files used for	Medicare payment.	Global totals for matpractice $RVUs$ may not sum due to rounding
	ĕ																																									61 4	- 12	ē t	3	ř
CPT1.3	HCPCS Mod	34013	34011	34870	34825	34826	34830	34831	34832	34833	34834	34900	3491F	3497F	3498F	35001	35002	35005	35011	35013	35021	35022	35045	35081	35082	35002	35102	35103	3510F	35111	35112	3511F	35121	35122	3512F	35131	3513F	35141	35142	3514F		Re.	esta	T.	Med	ğ

	Global	XX	060	060	060	060	060	3 8	060	060	060	060	060	060	060	060	060	060	060	060	3 8	2 6	060	060	060	060	777	060	060	060	777	9 6	200	060	260	060	060	060	060	060	060							
Mai	Practice RVUs 3.4	0.00	4.33	4.16	4.33	3.63	5.98	00:0	C. 7	20.2	90.9	7.42	8.44	7.93	8.59	4.07	4.39	4.49	4.64	20.4	00.0	4.60	4.34	5,66	1.55	4.45	61.1	4.80	2.60	4.56	88′0	4.79	3.96	3.01	3.52	3,68	4.65	5.28	6.38	1.93	2.09	ıts		een	Tie for CPT	- 5 10 10 10 10 10 10 10 10 10 10 10 10 10		
Facility	RVUs ^{2,3}	0.00	8.27	9.23	9.94	8.65	12.43	00.00	13.85	14.42	10.88	13.16	14.56	13.77	17.85	7.88	8.36	13.07	10.53	4.0	5.5	12.72	0.82	12.02	11,62	6.77	2.19	10.73	12.35	10.10	1.69	12.22	8.60	6.28	10.29	8.21	8.76	11.54	12.53	13.78	14.74	ion. All Righ		alues have b	ent. Ped in the P.V	he files used		
Non- Facility	RVUs ^{2,3}	0.00	Z Y	YZ V	NA	Y.	NA S	0.00	V V	: Z	NA	NA	NA	NA	V.	Z A	NA:	NA :	Y ;	AN S	0.00	K	ζ <u>γ</u>	N.	NA	NA	NA	ΑN	NA V	ΑN	Y.	V,	Y :	Y :	YZ.	ΝA	NA	ΝA	ΥN	ΥN	ΑN	ical Associat		le that these v	edicare paym	reflected in t		
Physi- cian	Work RVUs ^{2,3}	0.00	24.00	23.05	24.00	21.59	31.47	0.00	20.20	38.00	33.60	41.75	46.82	43.98	49.20	22.57	24.34	27.72	26.62	23.00	000	35.90	25.00	32.22	29.00	25.39	18.9	27.62	32.22	26.08	4.94	26.99	22.36	16.71	21.74	20.95	25.79	29.06	35.90	36.00	38.98	unerican Med		are, please no	ot used for M	n will only be		to rounding.
	Description	Intrmed rsk thromboembolism	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Hgh risk for thromboembousm	Artery bypass grant	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	runt measurement performed	Artery bypass gran	Artery bypass grant	Artery bypass graft	Artery bypass graft	Artery bypass graft	Harvest femoropopliteal vein	Vein bypass graft	Vein bypass graft	Vein bypass graft	Harvest art for cabg add-on	Artery bypass graft	Bypass graft, not vein	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		2 If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The hadret neutrality reduction from the obtomentic demonstration is not reflected in the BVI is for CPT.	i ne bunget neudanty reduction from the can opractic demoustation is not reflected in the Kivos codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for		Global totals for malpractice RVUs may not sum due to rounding.				
	Status	}	Ą	٧	٧	¥	Ą.		< <	(∢	< <	Ą	٧	٧	٧	¥	٧	Ą	∢ .	۷.		< <	< ∢	: <	Ą	¥	4	٧	٧	∢	٧	۷.	₹ .	∢	<	٧	¥	٨	٧	¥	٧	des and	þ	es are refi	led as a co	luget neur 1940, 989	Medicare payment	totals for
	Mod																																									CPTC	Reserved.	² If value	Stablish	codes 98	Medicar	, Global
:	CPT"/ HCPCS	3551F	35521	35522	35523	35525	35526	3552F	35331	35535	35536	35537	35538	35539	35540	35548	35549	35551	35556	35558	3333F	35560	35503	35566	35570	35571	35572	35583	35585	35587	35600	35601	35606	35612	35616	35621	35623	35626	35631	35632	35633							
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냚		060 95						000																							80	\$5								35 090					Ta	5		
	Practice 3 RVUs ^{2,3,4} (2.66	3.23						100 67:1		1.00		0.99	0.87	0.73	98'0	1.07	09'0	1.99	1.35	1.20	67.1	05.1	8 = =	1.37	0.74	0.89	1.35		1.13			4.94	5.05	00.00	4.38	3.99	4.29	4.69	4,35	4.07	Riphts	:)	ive been	D VI le for CDT	e R VUS 101 CF 1		
		2.66	3.23		0.52	191	1.17		67.1		00.1		0.99	0.87	0.73	98'0	1.07	09'0	1.99	1.35	1.20		05.1		1.37	0.74		1.35		1.13	12.56 5.08		4.94	5.05	00'0	4.38		4.29	4.69	4,35		ation. All Riphts		values have been	ment.	icted in the KVOS for CF1		
Facility	Practice 3 RVUs ^{2,3,4} (6.45 2.66	7.45 3.23	1.00 0.56	0.91 0.52	3.32 1.61	2.46 1.17	2.11	2.38 (.23	2.90	2.25 1.00	2.93 1.03	3.45 0.99	2.41 0.87	0.73	2.54 0.88	3.20 1.07	2.14 0.60	1.99	2.74 1.35	2.01 1.20	2.99 1.29	3.03 1.06	8 2	3.06 1.37	2.68 0.74	3.18 0.89	3.97 1.35	3.63 1.08	2.07 1.13	12.56	9.70	11.00 4.94	10.89 5.05	00.00	8.11 4.38	3.99	7.98 4.29	10.80 4.69	4,35	4.07	ical Association. All Rights		te that these values have been	edicare payment.	reflected in the files used for		
Facility	PE Practice RVUs ^{2,3} RVUs ^{2,3,4} (6.45 2.66	NA 7.45 3.23	1.00 0.56	NA 0.91 0.52	NA 3.32 1.61	NA 2.46 1.17	NA 2.11 1.00	2.38 (.23	NA 2 99 1 46	NA 2.25 1.00	48.20 2.93 1.03	47.82 3.45 0.99	36.39 2.41 0.87	35,28 2,13 0,73	47.75 2.54 0.88	39.25 3.20 1.07	31.10 2.14 0.60	NA 3.21 1.99	NA 2.74 1.35	NA 2.01 1.20	NA 2.99 1.29	3.03 1.06	NA 421 1.18	NA 3.06 1.37	NA 2.68 0.74	NA 3.18 0.89	NA 3.97 1.35	NA 3.63 1.08	NA 2.07 1.13	NA 12.56	NA 9.70	NA 11.00 4.94	NA 10.89 5.05	0.00 0.00 0.00	NA 8.11 4.38	NA 7.40 3.99	NA 7.98 4.29	10.80 4.69	8.02 4.35	NA 7.52 4.07	American Medical Association. All Rights		are, please note that these values have been	tot used for Medicare payment.	demonstration is not reflected in the K VOS for C.r.i n will only be reflected in the files used for		to rounding.
Non- Facility Facility	Work PE PE Practice Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,4} (A Rechanneling of artery 15.23 NA 6.45 2.66	Rechanneling of artery 18.50 NA 7.45 3.23	Reoperation, carotid add-on 3.19 NA 1.00 0.56	Angioscopy 3.00 NA 0.91 0.52	Repair arterial blockage 10.05 NA 3.32 1.61	Repair arterial blockage 6.90 NA 2.46 1.17	Repair arterial blockage 6.03 NA 2.11 1.00	Kepatrarterial blockage 7.34 NA 2.35 1.23	NA 2 99 1 46	Renair venous blockage 6.03 NA 2.25 1.00	Repair arterial blockage 8.62 48.20 2.93 1.03	Repair arterial blockage 10.05 47.82 3.45 0.99	Repair arterial blockage 6.90 36.39 2.41 0.87	Repair arterial blockage 6.03 35.28 2.13 0.73	Repair arterial blockage 7.35 47.75 2.54 0.88	9.48 39.25 3.20 1.07	Repair venous blockage 6.03 31.10 2.14 0.60	Atherectomy, open 11.06 NA 3.21 1.99	Atherectomy, open 7.60 NA 2.74 1.35	Atherectomy, open 6.64 NA 2.01 1.20	Atherectomy, open 8.09 NA 2.99 1.29	Advantagement of the NA 2.47 1.60	transports 11.06 NA 4.21 1.18	Atherectomy, percutaneous 7.60 NA 3.06 1.37	Atherectomy, percutaneous 6.64 NA 2.68 0.74	Atherectomy, percutaneous 8.09 NA 3.18 0.89	10.42 NA 3.97 1.35	9.48 NA 3.63 1.08	NA 2.07 1.13	28.99 NA 12.56	25.23 NA 9.70	25.99 NA 11.00 4.94	NA 10.89 5.05	0.00 0.00 0.00	NA 8.11 4.38	NA 7.40 3.99	23.79 NA 7.98 4.29	Artery bypass graft 25.99 NA 10.80 4.69	Artery bypass graft 24.11 NA 8.02 4.35	22.57 NA 7.52 4.07	Foodes and descriptions only are converient 2009 American Medical Association. All Rights	vector was recent process and the replication was a consistent and the second s	alues are reflected for codes not payable by Medicare, please note that these values have been	lished as a courtesy to the general public and are not used for Medicare payment.	e budget neutratity reduction from the chropractic demonstration is not reflected in the K VUS for U.F.). OSOMO OSOMI and OSOMO. The required reduction will only be reflected in the files used for	care bayment.	bal totals for malpractice RVUs may not sum due to rounding.
Physi. Non- cian Facility cian Facility	Work PE Practice Work PE Practice Secription RVUs ^{2,3} RVUs ^{2,3,4} (A Rechanneling of artery 15.23 NA 6.45 2.66	Rechanneling of artery 18.50 NA 7.45 3.23	Reoperation, carotid add-on 3.19 NA 1.00 0.56	Angioscopy 3.00 NA 0.91 0.52	Repair arterial blockage 10.05 NA 3.32 1.61	Repair arterial blockage 6.90 NA 2.46 1.17	Repair arterial blockage 6.03 NA 2.11 1.00	Kepatrarterial blockage 7.34 NA 2.35 1.23	Repair arterial blockage 8.40 NA 2.00 1.30	Renair venous blockage 6.03 NA 2.25 1.00	Repair arterial blockage 8.62 48.20 2.93 1.03	Repair arterial blockage 10.05 47.82 3.45 0.99	Repair arterial blockage 6.90 36.39 2.41 0.87	Repair arterial blockage 6.03 35.28 2.13 0.73	Repair arterial blockage 7.35 47.75 2.54 0.88	Repair arterial blockage 9.48 39.25 3.20 1.07	Repair venous blockage 6.03 31.10 2.14 0.60	Atherectomy, open 11.06 NA 3.21 1.99	Atherectomy, open 7.60 NA 2.74 1.35	Atherectomy, open 6.64 NA 2.01 1.20	Atherectomy, open 8.09 NA 2.99 1.29	Advantagement of the NA 2.47 1.60	Atherectomy permaneous 11.06 NA 4.21 1.18	Atherectomy, percutaneous 7.60 NA 3.06 1.37	Atherectomy, percutaneous 6.64 NA 2.68 0.74	Atherectomy, percutaneous 8.09 NA 3.18 0.89	10.42 NA 3.97 1.35	Atherectomy, percutaneous 9.48 NA 3.63 1.08	Harvest vein for bypass 6.44 NA 2.07 1.13	28.99 NA 12.56	25.23 NA 9.70	25.99 NA 11.00 4.94	27.99 NA 10.89 5.05	0.00 0.00 0.00	24.29 NA 8.11 4.38	Artery bypass graft 22,12 NA 7.40 3.99	Artery bypass graff 23.79 NA 7.98 4.29	Artery bypass graft 25.99 NA 10.80 4.69	Artery bypass graft 24.11 NA 8.02 4.35	22.57 NA 7.52 4.07	Option and descriptions only are convirient 2009 American Medical Association. All Rights	Reserved.	If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the KVOS for Criticals objected in the files used for	Medicare bayment.	⁴ Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been 2 if values are reflected for codes not payable by Medicare, please not stablished as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

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	Global	060	060	060	060	060	060	060	XXX	000	000	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	777	XXX	XXX	XX	222	060	060	060	λλλ	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
Mal- Practice	RVUs ^{2,3,4}	3.39	4.04	4.43	1.43	1.62	6.02	6.50	0.01	0.21	0.08	0.25	0.28	0.31	0.24	0.23	0.26	0.38	0.22	0.24	0.18	0.23	0.40	0.43	0.55	69:0	0.11	0.42	0.58	0.71	0.10	1.59	1.00	09:0	0.00	0.02	0.05	0.01	0.01	0.00	00:0	0.07	0.05	ghts	
Facility	RVUs ^{2,3}	20.7	8.82	8.13	4.92	5.43	10.82	13,23	0.07	0.81	0.30	0.75	1.01	1.10	0.79	0.95	1.09	0.97	0.58	0.63	0.63	97.0	0.93	1.54	1.74	2.10	0.33	1.53	99.1	1.98	0.31	6.18	3.55	3.36	00'0	0.14	0.11	0.07	0.07	NA	NA	0.38	0.28	tion. All Rig	
Non- Facility PE	RVUs23	۷ Z	Z A	ΥN	Z.	ΑN	NA V	ΑN	0.41	2.12	4.54	8.54	14.13	13.79	12.62	13.22	13.94	7.81	7.42	7.52	8.35	7.72	9.83	16.69	18.01	34.68	3.18	16.52	17.20	32.08	2.47	N.	Ϋ́	K K	0.00	0.37	0.38	0.31	0.35	0.21	0.21	NA	NA	dical Associa	
Physi- cian Work	RVUs ^{2,3}	19.22	23.07	24.57	8.26	9.44	33.39	37.14	0.18	1.96	0.95	2.43	3.14	3.51	2.52	3.02	3.51	3.02	2.01	2.01	2.01	2.52	3.02	4.67	5.27	6.29	10.1	4.67	5.27	6.29	10.1	9.82	5.55	4.05	00'0	0.38	0.31	81.0	81.0	0.00	0.00	101	0.76	American Me	
	Description	Revise graft w/vein	Revise graft w/nonauto graft	Revise graft w/vein	Excision, graft, neck	Excision, graft, extremity	Excision, graft, thorax	Excision, graft, abdomen	Place needle in vein	Pseudoaneurysm injection trt	Injection ext venography	Place catheter in vein	Place catheter in vein	Place catheter in vein	Place catheter in artery	Place catheter in artery	Place catheter in artery	Establish access to artery	Establish access to artery	Establish access to artery	Artery to vein shunt	Establish access to aorta	Place catheter in aorta	Place catheter in artery	Place catheter in artery	Place catheter in artery	Insertion of infusion pump	Revision of infusion pump	Removal of infusion pump	Vessel injection procedure	Bl draw < 3 yrs fem/jugular	Bl draw < 3 yrs scalp vein	Bl draw < 3 yrs other vein	Non-routine bl draw > 3 yrs	Routine venipuncture	Capillary blood draw	Vein access cutdown < 1 yr	Vein access cutdown > 1 yr	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights						
	Status	¥	٧	∢	٧	Ą	٧	Ą	¥	٧	٧	Ą	٧	<	٧	¥	٧	4	∢	٧	4	Ą	٧	¥	٧	4	Ą	4	Ą	¥	٧	٧	4	¥	၁	Ą	Ą	Ą	Ą	×	В	₹	Ą	des and o	
	Mod																																											CPT co	Reserved
CPT ¹³	HCPCS	35881	35883	35884	35901	35903	35905	35907	36000	36002	36005	36010	36011	36012	36013	36014	36015	36100	36120	36140	36145	36160	36200	36215	36216	36217	36218	36245	36246	36247	36248	36260	36261	36262	36299	36400	36405	36406	36410	36415	36416	36420	36425		
	23.4 Global																																				060 89:9	1.77 090	060 911			060 80			
Mah	RVU	1.89	5.7	5.78	5.9	3.4	3.4	5.74	5.2	3.62	4.2	4.5	3.5	3.5	4.	3.87	4	3.5	0.2	1.2	1.5	0.7	0.5	33	2.8	3.4	3.6	0.53	0.5		1.31	00.0	0.0	1.46	0.9	1.2	9.9	1.7	Ξ	4.4	8:	3.08	3.03	Rights	
Facility	RVU62	13.52	10,34	12.69	12,74	7.16	7.91	12.51	11.26	8.12	12.42	10.10	8.27	8.53	9.38	8.83	10.09	9.03	0.50	2.14	2.30	1.21	1.02	6.56	6.36	6.80	7.01	16.0	0.95	5.39	4.19	0.00	0.00	4.69	4.14	4.75	14.18	5.90	3.97	8.37	5.03	7.30	7.27	ation. All	
Non- Facility PE	RVUs23	ΥN	NA	NA	NA	NA	NA	ΝA	NA	NA	AN	NA	NA	NA	NA	NA A	NA	N V	NA	N.	NA	NA	NA.	V.	NA	NA	NA	NA	NA	ΝA	NA	0.00	00.0	NA	NA	NA	N A	NA	NA	NA	Ν	X	NA	ical Associ	
Physi- cian Work	RVUs ^{2,3}	35.20	31.62	32.92	33.47	18.85	18.34	32.84	29.62	20.08	25.97	26.17	20.39	20.22	23.80	22.22	23.53	20.64	1.60	7.19	8.49	4.04	3.34	18.32	15.64	19.19	19.97	3.00	3.08	9.11	7.66	0.00	0.00	8.61	5.84	7.99	36.81	10.87	6.72	24.39	10.64	17.74	17.28	American Med	
	Description	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Artery bypass graft	Composite bypass graft	Composite bypass graft	Composite bypass graft	Bypass graft patency/patch	Bynass praff/av fist natency	Arterial transposition	Arterial transposition	Arterial transposition	Arterial transposition	Reimplant artery each	Reoperation, bypass graft	Exploration, carotid artery	Exploration, femoral artery	Pt consid poss risk fx	Pt not consid poss risk fx	Exploration popliteal artery	Exploration of artery/vein	Explore neck vessels	Explore chest vessels	Explore abdominal vessels	Explore limb vessels	Repair vessel graft defect	Removal of clot in graft	Removal of clot in graft	Revise graft w/vein	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	
	Statue	Ą	¥	₹	¥	4	4	<	∀	< <	V	4	V	*	∢	*	. ∢	₹	. ∢	. ∢	: ∢	: ∢	. ∢	. ∢	. ∢	<	<<	٧	¥	٧	٧	-	-	4	٧	¥	*	¥	٧	٧	. ∢	₹	∀	odes and	· -c
	Mod																																											CPT	Reserved
, ⁶³ T42	HCPCS	35634	35636	35637	35638	35642	35645	35646	35647	35650	35651	35654	35656	35661	35663	35665	35666	35671	35681	35682	35683	35685	35686	35691	35693	35694	35695	35697	35700	35701	35721	3572F	3573F	35741	35761	35800	35820	35840	35860	35870	35875	35876	35879		

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been if values are reflected for codes not payable and are not used for Medicare payment.

The budget neutrality reducing from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malgractice RVUs may not sum due to rounding.

Reserved.

Trigulesca are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payament.

The budget neutrality reduction from the chicopractic demonstration is not reflected in the RVIs for CPT codes 19840, 19841, and 98941, and 98941, and 98941, and 98941, and 98941, and 98941, and practice from the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

Part		Global	010	000	010	010	010	XXX	XXX	XXX	000	000	8	3 8	200	ž	000	000	000	000	900	000	000	900	800	060	060	060	060	060	060	060	060	060	060	060	060	060	000	000	060	060	060	060	060								
Mod. Skaue Denserition Name Facility Math. Name Pacific Name	Mal- Practice	RVUs ^{2.3.4}	0.85	60.0	0.50	0.26	0.47	0.00	0.00	00'0	0.30	0.07	010	2.0	0.05	0.02	0.07	0.32	0.26	0.27	0.12	280	0.50	0.47	701	2.46	244	2.03	0.97	3.76	1.68	2.05	1.35	1.78	2.03	1.89	1.34	3.73	0.15	0.36	0.52	4.07	434	4.17	4.23	hts		een		'Us for CPT	for		
Mod. Skaue Denserition Name Facility Math. Name Pacific Name	Facility PE	RVUs.	3.15	95.0	2.42	1.35	1.91	NA	ΝΑ	Y Z	1.28	0.41	0.40	2 6	0.23	60.0	0.21	19:0	40.1	0.22	0.29	177	1 60	1 29	85.5	6.37	6.55	5.98	4.19	11.08	5.18	5.14	3.93	4.66	5.16	5.17	5.10	8.67	0.80	1.48	2.66	12.10	12.39	11.36	12.48	ion. All Righ		alues have b	ent.	ted in the RV	he files used		
Mod. Skaue Denserition Name Facility Name Name	Non- Facility PE	RVUs23	28.34	3.79	22.15	2.00	4.08	0.51	0.57	89.0	10.22	2.48	7.90	00.0	2.00	0.46	ΥZ	NA	A'N	· Z	Z Z	. A	Z Z	Z	Z V	ξ Z	Z	A'N	NA A	ΥZ	Y Z	V Z	ΥZ	NA	ΑN	Ν	NA	ΝA	3.28	۷ N	32.07	Ν	ΥV	ΝA	ΝĀ	lical Associat		te that these v	edicare paym	is not reflect	reflected in t		
Mod. Skaue Denserition Name Facility Math. Name Pacific Name	Physi- cian Work	RVUs23	5.26	1.20	4.81	2.27	3.32	0.00	0.00	0.00	3.59	0.75	2.5	17.1	0.74	0.32	1.15	2.11	2.10	140	1.20	2.43	3 96	262	1811	14 30	14 30	12.00	5.51	22.82	10.00	12.00	8.01	10.50	11.95	11.11	7.43	21.59	2.01	2.52	5.17	25.12	26.13	23.13	26.13	merican Med		are, please no	ot used for M	demonstration	a will only be		to rounding.
Mod. Skaue Denserition Name Facility Name Name		Description	Replace tunneled cv cath	Replace picc cath	Replace picyad cath	Removal tunneled cv cath	Removal tunneled cv cath	Draw blood off venous device	Collect blood from picc	Declot vascular device	Mech remov tunneled cv cath	Mech remov tunneled cy cath	Descrition various cathoday	repusition venous cauteter	Inj w/fluor, eval cy device	Withdrawal of arterial blood	Insertion catheter, artery	insertion catheter, artery	Insertion catheter, artery	Insertion catheter atten	Insert needle, hone cavity	Incertion of cannula	Insertion of cannida	Insertion of cannula	An firea unar arm conholic	Av fise uppr arm, ceptianc	Av fusion/forearm vein	Ay fusion direct any site	Insertion of cannula(s)	Insertion of cannula(s)	Artery-vein autograft	Artery-vein nonautograft	Open thrombect av fistula	Av fistula revision, open	Av fistula revision	Repair A-V aneurysm	Artery to vein shunt	Dist revas ligation, hemo	External cannula declotting	Cannula declotting	Percut thrombect av fistula	Revision of circulation	Revision of circulation	Revision of circulation	Revision of circulation	descriptions only are copyright 2009 A		lected for codes not payable by Medica	ourtesy to the general public and are no	rality reduction from the chiropractic	41, and 98942. The required reduction	£	malpractice RVUs may not sum due t
Mod. Skaue Denserition Name Facility Name Name		Status	¥	4	4	Κ	٧	H	H	٧	¥	4	(<	ς :	_	¥	¥	4	~	: 4	; ∢	: ∢	: ∢	; ∢	< ⊲	< ⊲	; ∢	. ⋖	٧	4	٧	K	4	4	<	٧	₹	<	∢	۷	Ą	¥	٧	Ą	¥	odes and	, q	es are refl	hed as a co	adget neut	8940,989	re paymen	totals for
Mode Status	CPT ¹³ /		36583	36584	36585	36589	36590	36591	36592	36593	36595	36598	36507	36397	36298	36600	36620	36625	36640	36660	36680	36800	36810	36815	26919	36818	36820	36821	36822	36823	36825	36830	36831	36832	36833	36834	36835	36838	36860	36861	36870	37140	37145	37160	37180	CPT	Reserve	2 If valu	establis	3 The b	6 sapos	Medica	4 Globa
Mod Status Description Physiol Physi																																																					
Mod Status Description Physiol Physi				XXX	XXX	XXX	XXX	000	000	010	010	000	222	7777	900	222	000	000	000	000	900	900	000	000	000	000	000	000	010	010	010	010	010	010	010	000	000	010	010	000	010	010	000	010	010					PT.			
Mod Status Description Physiol Physi													-	•																													0.12 000	0.30 0.10	0.67 010	Lights		e been		R VUs for CPT	ed for		
5.0	Mal- Practice	RVUs ^{2,3,4} G	0.00	0.19	0.16	0.11	1.07	0.00	0.00	0.13	0.21	501	530	0.33	0.92	0.48	09'0	0.39	0.08	010	2 =	0.77	110	0.13	0.00	0.00	0.0	0.22	0.83	0.54	0.45	0.82	96'0	96'0	0.93	0.14	0.14	0.39	0.74	90'0	0.43	0,40	0.12	1.68 0.30 010		tion. All Rights		values have been	nent.	cted in the RVUs for CPT	the files used for		
5.0	Facility Mat-	RVUs" RVUs"" C	NA 0.00	0.39 0.19	0.87 0.16	0.96 0.11	2.44 1.07	0.00 0.00	0.00 0.00	0.78 0.13	0.94 0.21	230 1.05	50:1 60:2	1,06 0,33	2.36 0.92	1.11 0.48	NA 0.60	1.14 0.39	0.43 0.08	01.0	27:0	0.74	0 065	0.66	21:0	0.00	0.00	0.69 0.22	3.09 0.83	2.42 0.54	2.66 0.45	3.10 0.82	3.32 0.96	2.92 0.96	3.22 0.93	0.61 0.14	0.62 0.14	2.52 0.39	2.88 0.74	0.25 0.06	1.79 0.43	2.04 0.40	0.46 0.12	3	6 2.68	ical Association. All Rights	· ·	e that these values have been	edicare payment.	is not reflected in the RVUs for CPT	reflected in the files used for		
5.0	Non- Facility Facility Mat- PE Practice	2 RVUs ^{2,3} RVUs ^{2,3,4} C	0.74 NA 0.00	NA 0.39 0.19	NA 0.87 0.16	NA 0.96 0.11	NA 2.44 1.07	0.00 0.00 0.00	0.00 0.00 0.00	2.65 0.78 0.13	2.82 0.94 0.21	20 1 01 01 01	5011 401 1177	0./1 1.06 0.33	27.72 2.36 0.92	6,76 1.11 0.48	3.03 NA 0.60	NA 1.14 0.39	1.28 0.43 0.08	010 CLU VN	11.0 12.0 AN	NA 0.74 0.33	10 59 0 63	4535 066 012	47.33 0.46 0.09	200 0.00	3.64 0.45 0.16	3.32 0.69 0.22	19.99 3.09 0.83	14.84 2.42 0.54	18.18 2.66 0.45	23.75 3.10 0.82	26.07 3.32 0.96	19.21 2.92 0.96	124.70 3.22 0.93	5.00 0.61 0.14	4.29 0.62 0.14	21.12 2.52 0.39	26.80 2.88 0.74	3.37 0.25 0.06	6.36 1.79 0.43	9.29 2.04 0.40	4.01 0.46 0.12	15.33	22.46 2.68	American Medical Association. All Rights	Constitution of the consti	are, please note that these values have been	ot used for Medicare payment.	demonstration is not reflected in the RVUs for CPT	n will only be reflected in the files used for		to rounding.
	Non- Facility Facility Mat- PE Practice	Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} C	0.00 0.74 NA 0.00	1.03 NA 0.39 0.19	Bl exchange/transfuse, ub 2.23 NA 0.87 0.16	Blexchange/transfuse non-ub 2.43 NA 0.96 0.11	Transfusion service, fetal 6.58 NA 2.44 1.07	Injection(s), spider veins 0.00 0.00 0.00 0.00	Injection(s), spider veins 0.00 0.00 0.00 0.00	Injection therapy of vein 1.09 2.65 0.78 0.13	Injection therapy of veins 1.60 2.82 0.94 0.21	577 3014 230 1.05	Engovernment, 181 vgm 0.72 55.14 2.55 1.05	Endovendus II, vela add-oa 3.38 0.71 1.06 0.33	Endovenous laser, 1st vein 6.72 27.72 2.36 0.92	Endovenous laser vein addon 3.38 6.76 1.11 0.48	Insertion of catheter, vein 6.98 3.03 NA 0.60	Insertion of catheter, vein 3.51 NA 1.14 0.39	Insertion of catheter, vein 1.09 1.28 0.43 0.08	Ambanacia with 174 MA 0.72 0.10	Applications with the contraction of the contractio	Applications (Or NA 0.22	Appareis planting 174 10.57 0.11	Apprecia planutambica 174 45.35 0.65 0.12	Appliciosis, ausolipticalities 1.74 45.55 0.00 0.12	Apprehensis, selective 1.22 47.35 0.49 0.06	Theory non-hung over the control of	Insert non-hunnel cy cath 2 50 3.32 0.69 0.22	Insert tunneled cv cath 5.11 19.99 3.09 0.83	Insert tunneled cv cath 4.81 14.84 2.42 0.54	Insert tunneled cv cath 6.26 18.18 2.66 0.45	Insert tunneled cv cath 6.01 23.75 3.10 0.82	Insert tunneled cv cath 6.21 26.07 3.32 0.96	Insert tunneled cv cath 6.01 19.21 2.92 0.96	Insert tunneled cv cath 6.51 124.70 3.22 0.93	Insert picc cath 1.92 5.00 0.61 0.14	Insert picc cath 1.82 4.29 0.62 0.14	Insert picyad cath 5,33 21.12 2.52 0.39	5.31 26.80 2.88 0.74	Repair tunneled cv cath 0.67 3.37 0.25 0.06	Repair tunneled cv cath 3.21 6.36 1.79 0.43	Replace tunneled cv cath 3.51 9.29 2.04 0.40	Replace cvad cath 1.31 4.01 0.46 0.12	Replace tunneled ov cath 3.45 15.33	Replace tunneled cv cath 5.21 22.46 2.68	PT codes and descriptions only are convright 2009 American Medical Association. All Rights	Padda	yealises are reflected for codes not payable by Medicare, please note that these values have been	ablished as a courtesy to the general public and are not used for Medicare payment.	he budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	des 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dicare payment.	Hobal totals for malpractice RVUs may not sum due to rounding.

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Mal- Practice	RVUs 23.4	2.59	46.	3.22	0.00	0.07	0.46	0.45	0.51	16.0	060	0.63	0.46	550	6.00	0.00	136	1.66	0.75	2.18	2.35	0.00	0.05	0.12	80.0	0.18	0.01	0.05	0.07	60.0	0.18	0.24	0.21	0.12	0.07	0.15	0.22	0.88	0.88	0.68	2.48	1.87	0.00	0.07	ghts		peen	VI to for CPT	d for		
Facility	RVU62.3	7.80	9.80	11.54	0.00	0.72	4.85	4.30	4.43	6.54	7.00	4.97	3,66	5.5	70.4	5.58	9.73	11,17	7.62	11.96	12.36	0.00	2.00	2.82	2.14	3.24	0.56	1.70	1.87	2.55	4.1	4.24	4.06	3.41	2.99	2.30	3.05	97.9	8.23	7.24	10,60	12.88	0.00	1.47	tion. All Ri		values have	ient.	the files used		
Non- Facility PF	RVUs23	V ;	ď	Y Z	00.00	2.01	8.26	7.34	7.56	Ϋ́Z	∢ Z	8.27	6.77	20.0	¥. 0	8.84	۷ Z	NA NA	Y.	Y'X	Ϋ́	0.00	3.85	4.95	4.19	5.39	2.24	3.55	3.73	4.63	5.95	6.24	60.9	5.10	5.22	4.56	5.71	11.23	13.27	12.86	16.43	18.55	00.0	2.64	lical Associa		te that these	edicare paya	reflected in		
Physi- cian Work	RVU.	14.58	12.97	19.75	00.0	1.22	4.35	4.74	4.71	7.61	9.20	5.45	1,69	2.03	4.32	5.57	13.97	17.03	14.09	14.54	15.69	0.00	1.19	2.57	1.26	2.73	0.31	86.0	1.33	2.33	3,45	3.70	2.72	2.45	1.30	1.78	2.50	9.03	9.03	12.62	16.57	19.13	00.0	1.32	merican Med		re, please no	of used for Ma	will only be	. ;	o rounding.
	Description	Revision of diaphragm	Resect diaphragm, simple	Resect diaphragm, complex	Diaphragm surgery procedure	Biopsy of lip	Partial excision of lip	Partial excision of lip	Partial excision of lip	Reconstruct lip with flap	Reconstruct lip with flap	Partial removal of lin	Renair lin	Description	Kepair up	Kepaur lip	Repair cleft lip/nasal	Repair cleft lip/nasal	Repair cleft lip/nasal	Repair cleft lip/nasal	Repair cleft lip/nasal	Lip surgery procedure	Drainage of mouth lesion	Drainage of mouth lesion	Removal, foreign body, mouth	Removal, foreign body, mouth	Incision of lip fold	Biopsy of mouth lesion	Excision of mouth lesion	Excise/repair mouth lesion	Excise/repair mouth lesion	Excision of mouth lesion	Excise oral mucosa for graft	Excise lip or cheek fold	Treatment of mouth lesion	Repair mouth faceration	Repair mouth laceration	Reconstruction of mouth	Reconstruction of mouth	Reconstruction of mouth	Reconstruction of mouth	Reconstruction of mouth	Mouth surgery procedure	Drainage of mouth lesion	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for intedicate payment. The hardest neutrality section from the chirowactic demonstration is not reflected in the PVI is for CPT.	the proget neutrany reduction from the controp active demonstration is not respected in the files used for codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for		Global totals for malpractice RVUs may not sum due to rounding
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, e j. m. s.	HCPCS Mod	39545	39560	39561	39599	40490	40500	40510	40520	40525	40527	40530	40650	00004	40632	40654	40700	40701	40702	40720	40761	40799	40800	40801	40804	40805	40806	40808	40810	40812	40814	40816	40818	40819	40820	40830	40831	40840	40842	40843	40844	40845	40899	41000	CPT	Reserved	If val	estabu ³ The	səpoo	Medic	dolD.
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	RVU813 RVU8114	0.82	4.66 1.06	4.41 1.02	5.33 1.37	5.39 1.00	1.13	9.07 2.50	6.51 1.29	1.59	4.42 0.95	105	7.47	0000	0.00	8.32 1.30	12.97 2.48	14,21 2.48	6.50 1.70	7.93 2.20	0.86	1.80 0.77	7.43 1.96	10.56 3.10	1.23	8.68 1.68	0.82 0.18	0.51 0.07	2.82 0.33	00:0 00:0	1.27	6.77 2.36	7.06 2.67	9.27 3.34	4.67 1.40	00:0 00:0	7.33 2.21	8.73 2.76	19.79	8.35 2.80	2.71	2.79	2.35	2.56	ical Association. All Rights	,	e that these values have been	edicare payment.	is not reflected in the K VOS for CF F reflected in the files used for		
Non- Facility Facility	RVUs ²³ RVUs ²³ RVus ^{23,4} C	6.43 3.99 0.82	4.66 1.06	4.41 1.02	5.33 1.37	NA 5.39 1.00	NA 5.48 1.13	NA 9.07 2.50	NA 6.51 1.29	NA 6.34 1.59	NA 4.42 0.95	NA 591 105	NA 747 100	, 000 (+1 W)	0.00 0.00	NA 8.32 1.30	NA 12.97 2.48	NA 14,21 2.48	NA 6.50 1.70	NA 7.93 2.20	NA 1.58 0.86	NA 1.80 0.77	NA 7.43 1.96	NA 10.56 3.10	NA 6.63 1.23	NA 8.68 1.68	NA 0.82 0.18	0.51 0.07	NA 2.82 0.33	0.00 0.00 0.00	NA 4.96 1.27	6.77 2.36	7.06 2.67	NA 9.27 3.34	NA 4.67 1.40	00:0 00:0	7.33 2.21	8.73 2.76	19.79	8.35 2.80	NA 7.93 2.71	2.79	2.35	2.56	merican Medical Association. All Rights		rre, please note that these values have been	of used for Medicare payment.	temoistration is not rejected in the K VOS for CF I will only be reflected in the files used for		o rounding.
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Non- Facility Facility	RYUS ²³ RYUS ²³ RYUS ²³ C	6.69 6.43 3.99 0.82	6.95 NA 4.66 1.06	Biopsy/removal, lymph nodes 6.35 NA 4.41 1.02	Biopsy/removal, lymph nodes 8.26 NA 5.33 1.37	Explore deep node(s), neck 7.85 NA 5.39 1.00	Removal, neck/armpit lesion 6.99 NA 5.48 1.13	Removal, neck/armpit lesion 15.42 NA 9.07 2.50	Removal, nelvic lymph nodes 10.92 NA 6.51 1.29	Removal, abdomen lymph nodes 11.29 NA 6.34 1.59	Lanaroscopy lymph node bion 9.28 NA 4.42 0.95	Tanaroscopy fumphadenectomy 14.70 NA 5.91 1.05	Language 1, 1 mphaganation 16.86 NA 7.47 1.00	Laparoscopy, tymphaadchoctodiy (0.50 1.50	Laparoscope proc, tymphatic 0.00 0.00 0.00	Removal of lymph nodes, neck 12.68 NA 8.32 1.30	Removal of lymph nodes, neck 21.72 NA 12.97 2.48	Removal of lymph nodes, neck 23.72 NA 14.21 2.48	Remove armoit formula nodes 10.57 NA 6.50 1.70	Remove armort lymph nodes [3.7] NA 7.93 2.20	Remove thoracic lymph nodes 4.88 NA 1.58 0.86	Remove abdominal forms nodes 4.88 NA 1.80 0.77	Remove groin lymph nodes 13.49 NA 7.43 1.96	Remove aron lymph nodes 21.78 NA 10.56 3.10	Remove pelvis lymph nodes 13.98 NA 6.63 1.23	Remove abdomen lymph nodes 17.56 NA 8.68 1.68	Inject for lymphatic x-ray 1.29 NA 0.82 0.18	Identify sentinel node 0.52 NA 0.51 0.07	Access thoracic lymph duct 4.51 NA 2.82 0.33	Blood/lymph system procedure 0.00 0.00 0.00 0.00	Exploration of chest 7.49 NA 4.96 1.27	Exploration of chest (3.11 NA 6.77 2.36	Removal chest lesion 15.04 NA 7.06 2.67	Removal chest lesion 19.47 NA 9.27 3.34	Visualization of chest 8.00 NA 4.67 1.40	Chest procedure 0.00 0.00 0.00 0.00	Repair diaphragm faceration 13.89 NA 7.33 2.21	Repair paraesophageal hernia 17.09 NA 8.73 2.76	Repair of diaphragm hernia 108.67 NA 19.79 17.60	Repair of diaphragm hernia 16.63 NA 8.35 2.80	Repair of diaphragm hernia 16.22 NA 7.93 2.71	Repair of diaphragm hernia 17.23 NA 8.78 2.79	Repair of diaphragm hernia 14.51 NA 7.25 2.35	15.67 NA 7.95 2.56	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved	² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtest to the general public and are not used for Medicare payment.	'n ne buoget beuraanty reduction from the convoyaethe demonstration is not renected in the Nos for Crit codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	4 Global totals for malyractice RVUs may not sum due to rounding.

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3.1. 6.0. 41823 R. Excision of gam keison 3.5 5.1 4.6 0.00 1.1. 6.0. 41825 A. Excision of gam keison 2.3 5.1 5.6 0.00 1.1. 6.0. 41826 A. Excision of gam keison 3.1 4.2 3.6 0.00 1.1. 6.0. 41827 R. Excision of gam keison 3.1 4.2 3.6 0.00 1.1. 6.0. 41829 R. Excision of gam keison 3.1 4.2 3.6 0.00 1.1. 6.0. 41829 R. Excision of gam keison 3.1 4.2 3.6 0.00 1.1. 6.0. 4.1870 R. Excision of gam keison 3.1 4.2 4.2 0.00 1.1. 6.0. 6.0. 6.0 0.0 0.0 0.0 0.0 1.1. 6.0. 6.0 6.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	0.33	A A	Drainage of mouth lesion	1.28	4.55	1.97	0.08	010		~	Excision of sum lesion	2.35	86.4	2.36	90:0	010
131 900 41825 A Excision of glam liston 135 516 106 131 900 41825 A Excision of glam liston 137 517 139 109 000 131 900 41827 A Excision of glam liston 317 714 244 249 000 131 900 41820 R Treatment of glan liston 318 6.56 339 0.00 131 900 41870 R Caramator of glan liston 0.00 0.00 0.00 0.00 131 900 41870 R Caramator of glan liston 0.00	0.18 090 41825 0.19 090 41826 0.11 090 41828 0.11 090 41830 0.11 090 41830 0.11 090 41830 0.11 090 41830 0.12 090 41870 0.03 010 41890 0.03 010 42104 0.03 010 42104 0.03 090 42104 0.04 090 42104 0.05 090 42104 0.05 090 42106 0.07 090 42205 0.08 090 42205 0.09 090 42205 0.09 090 42205 0.00 090 42205 0.00 090 42206 0.00 090 090 42206 0.00 090 090 090 090 090 090 090 090 090	<	Drainage of mouth lesion	3.28	5.94	3,30	0.32	060	41823	~	Excision of gum lesion	3.63	7.11	4.60	0.10	060
9.00 41825 A Excision of gum teston 235 507 280 0.00 10.11 90.00 41822 A Excision of gum teston 311 474 3.96 0.00 10.11 90.00 41820 R Excision of gum teston 311 474 3.96 0.00 10.11 90.00 41820 R Treatment of gun teston 0.00 <td>0.11 090 41826 0.11 090 41828 0.11 090 41839 0.11 090 41830 0.12 090 41870 0.13 090 41870 0.06 010 41870 0.06 010 41870 0.06 010 42100 0.07 010 42100 0.08 010 42100 0.09 010 42100 0.11 010 42100 0.12 090 42100 0.13 090 42200 0.14 090 42200 0.15 090 42200 0.16 090 42200 0.17 090 42200 0.18 090 42200 0.19 090 42200 0.10 090 090 090 090 090 090 090 090 090 0</td> <td>4</td> <td>Drainage of mouth lesion</td> <td>3.14</td> <td>5.92</td> <td>3.24</td> <td>0.31</td> <td>060</td> <td>41825</td> <td>¥</td> <td>Excision of gum lesion</td> <td>1.35</td> <td>3.65</td> <td>19.1</td> <td>90:0</td> <td>010</td>	0.11 090 41826 0.11 090 41828 0.11 090 41839 0.11 090 41830 0.12 090 41870 0.13 090 41870 0.06 010 41870 0.06 010 41870 0.06 010 42100 0.07 010 42100 0.08 010 42100 0.09 010 42100 0.11 010 42100 0.12 090 42100 0.13 090 42200 0.14 090 42200 0.15 090 42200 0.16 090 42200 0.17 090 42200 0.18 090 42200 0.19 090 42200 0.10 090 090 090 090 090 090 090 090 090 0	4	Drainage of mouth lesion	3.14	5.92	3.24	0.31	060	41825	¥	Excision of gum lesion	1.35	3.65	19.1	90:0	010
10 41822 A Excision of gam liston 317 719 396 0.01 111 900 41820 R Excision of gam liston 318 6.56 3.93 0.08 111 900 41820 R Framout of gam liston 318 6.56 3.93 0.08 115 900 41820 R Framout of gam liston 0.00 0	0.11 090 41827 0.11 090 41828 0.11 090 41830 0.11 090 41830 0.11 090 41830 0.11 090 41830 0.12 090 41872 0.08 010 41874 0.08 010 41874 0.09 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42106 0.01 010 010 010 010 010 010 010 010 010	4	Drainage of mouth lesion	3.40	9.60	3.15	0.18	060	41826	¥	Excision of gum lesion	2.35	5.07	2.80	80.0	010
0.10 41833 R. Excision of gam tissue 3.11 474 2.49 0.00 0.11 0.90 41830 R. R. Excision of gam tissue 3.31 4.74 2.49 0.00 0.15 0.90 41870 R. R. Gampard of gam tissue 0.00 <td< td=""><td>0.07 010 41828 0.11 090 41830 0.11 090 41830 0.13 090 41870 0.08 010 41874 0.08 010 4200 0.09 010 42104 0.00 010 42104 0.01 010 42104 0.02 090 42106 0.03 010 42180 0.04 020 42180 0.05 090 42180 0.07 090 42180 0.08 090 42206 0.09 090 42206 0.09 090 42206 0.00 090 000 42206 0.00 000 000 42300 0.00 000 000 42300</td><td>٧</td><td>Drainage of mouth lesion</td><td>3.63</td><td>16.5</td><td>3.50</td><td>0.14</td><td>060</td><td>41827</td><td>4</td><td>Excision of gum lesion</td><td>3.72</td><td>7.04</td><td>3.96</td><td>0.21</td><td>060</td></td<>	0.07 010 41828 0.11 090 41830 0.11 090 41830 0.13 090 41870 0.08 010 41874 0.08 010 4200 0.09 010 42104 0.00 010 42104 0.01 010 42104 0.02 090 42106 0.03 010 42180 0.04 020 42180 0.05 090 42180 0.07 090 42180 0.08 090 42206 0.09 090 42206 0.09 090 42206 0.00 090 000 42206 0.00 000 000 42300 0.00 000 000 42300	٧	Drainage of mouth lesion	3.63	16.5	3.50	0.14	060	41827	4	Excision of gum lesion	3.72	7.04	3.96	0.21	060
11 0.00 41830 R Fernancial of game instance 3.35 0.00 0.	0.111 0900 41830 0.151 0900 41830 0.155 0000 41870 0.08 0100 41871 0.08 0100 41872 0.09 0100 41872 0.09 0100 42104 0.01 0100 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42104 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.01 010 42105 0.02 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.03 010 42205 0.04 010 0 42300 0.05 010 000 42330 0.05 010 00 42330 0.05 010 00 42330 0.05 010 00 42330 0.05 010 00 42330	4	Incision of tongue fold	1.08	4.10	1.73	0.07	010	41828	~	Excision of gum lesion	3.11	4.74	2.49	80.0	010
0.00 41880 R Charament of gain lexion 0.00 0.00 0.00 0.00 0.11 0.00 41870 R Caum graff 0.00 0.00 0.00 0.00 0.08 0.00 41874 R Repair took socket 3.13 5.24 3.76 0.00 0.09 0.10 42000 A Divings upon book socket 3.13 5.87 3.20 0.00 0.00 0.09 0.10 42100 A Biopsy procedue 0.00 0.00 0.00 0.00 0.00 0.09 0.10 42100 A Biopsy procedue 0.00 0.00 0.00 0.00 0.09 42100 A Excision lesion month roof 1.23 2.9 1.87 0.09 0.10 42100 A Receive palate-festion 1.17 A A 1.87 A A 1.13 A 1.13 0.00 0.00 0.00 0.00 0.00 0.00	0.11 090 41850 0.15 090 41870 0.15 090 41870 0.08 010 41870 0.09 010 41870 0.00 010 42100 0.00 010 42100 0.01 010 42100 0.01 010 42100 0.02 090 42100 0.11 010 42145 0.11 010 42145 0.11 010 42145 0.11 010 42180 0.29 090 42180 0.29 090 42180 0.29 090 42210 0.29 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 42210 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 090 000 42280 0.20 000 000 42310 0.20 000 000 42310 0.20 000 000 42310 0.20 000 000 42310	<	Drainage of mouth lesion	4.00	6.93	4.85	0.11	060	41830	~	Removal of gum tissue	3.38	6.56	3.93	60.0	010
0.15 0.90 41870 R Gum graff 0.00 0.00 0.00 0.00 0.15 0.00 41874 R Repair tooth socket 0.00 <td>0.15 090 41870 0.15 090 41870 0.05 000 41874 0.08 010 41874 0.08 010 42100 0.09 010 42100 0.09 010 42100 0.09 010 42100 0.01 090 42100 0.01 090 42180 0.01 090 42180 0.02 090 42180 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.04 090 42280 0.05 090 42280 0.05 090 42280 0.05 090 42280 0.05 090 04235 0.06 090 04238 0.07 VYY 42300 0.08 090 42380 0.09 090 42280 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 000 042330 0.00 000 042330 0.00 000 000 042330 0.00 000 000 042330 0.00 000 000 042330</td> <td>⋖</td> <td>Drainage of mouth lesion</td> <td>4.11</td> <td>6.94</td> <td>4.98</td> <td>0.11</td> <td>060</td> <td>41850</td> <td>~</td> <td>Treatment of gum lesion</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>000</td> <td>000</td>	0.15 090 41870 0.15 090 41870 0.05 000 41874 0.08 010 41874 0.08 010 42100 0.09 010 42100 0.09 010 42100 0.09 010 42100 0.01 090 42100 0.01 090 42180 0.01 090 42180 0.02 090 42180 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.03 090 42280 0.04 090 42280 0.05 090 42280 0.05 090 42280 0.05 090 42280 0.05 090 04235 0.06 090 04238 0.07 VYY 42300 0.08 090 42380 0.09 090 42280 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 090 042380 0.00 000 042330 0.00 000 042330 0.00 000 000 042330 0.00 000 000 042330 0.00 000 000 042330	⋖	Drainage of mouth lesion	4.11	6.94	4.98	0.11	060	41850	~	Treatment of gum lesion	0.00	0.00	0.00	000	000
1487 R Repair tool socket 139 537 3.00 0.00 0508 41874 R Repair tool socket 130 537 3.76 0.00 0508 010 41899 C Demais urgery procedure 0.00 <th< td=""><td>0.055 0.00 4.1872 0.08 0.10 4.1874 0.08 0.10 4.1874 0.09 0.10 4.2000 0.09 0.10 4.2104 0.10 0.00 4.2110 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2105 0.27 0.90 4.2180 0.281 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2205 0.297 0.90 4.2205 0.298 0.90 4.2206 0.298 0.90 4.2206 0.298 0.90 4.2206 0.208 0.90 4.2206 0.209 0.10 4.2206 0.209 0.10 4.2206 0.200 0.10 4.2206 0.200 0.10 4.2306 0.200 0.10 4.2306 0.200 0.10 4.2306 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330</td><td>4</td><td>Drainage of mouth lesion</td><td>4.11</td><td>6.27</td><td>4.30</td><td>0.15</td><td>060</td><td>41870</td><td>~</td><td>Gum graft</td><td>0.00</td><td>0.00</td><td>0.00</td><td>00.0</td><td>000</td></th<>	0.055 0.00 4.1872 0.08 0.10 4.1874 0.08 0.10 4.1874 0.09 0.10 4.2000 0.09 0.10 4.2104 0.10 0.00 4.2110 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2104 0.11 0.10 4.2105 0.27 0.90 4.2180 0.281 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2180 0.297 0.90 4.2205 0.297 0.90 4.2205 0.298 0.90 4.2206 0.298 0.90 4.2206 0.298 0.90 4.2206 0.208 0.90 4.2206 0.209 0.10 4.2206 0.209 0.10 4.2206 0.200 0.10 4.2206 0.200 0.10 4.2306 0.200 0.10 4.2306 0.200 0.10 4.2306 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330 0.200 0.10 4.2330	4	Drainage of mouth lesion	4.11	6.27	4.30	0.15	060	41870	~	Gum graft	0.00	0.00	0.00	00.0	000
0.00 41874 R Regata rooth sector 31.13 3.13 3.10 0.10 0.08 0.10 41899 C Demais suggety procedure 0.00 0.00 0.00 0.00 0.00 0.08 0.10 42100 A Drainage mouth roof lesion 1.23 2.71 1.43 0.00 0.10 42100 A Drainage mouth roof lesion 1.23 2.71 1.43 0.00 0.10 42100 A Excision lesion, mouth roof 1.65 3.69 1.83 1.13 0.00 0.10 42100 A Excision lesion, mouth roof 1.65 3.69 1.83 1.13 0.00 0.10 42100 A Recover palace/lesion mouth roof lesion 1.81 7.00 4.31 0.00 0.10 42100 A Recover palace/lesion mouth roof lesion 1.81 7.00 9.00 4.21 0.00 9.01 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 <	0.08 0.00 4.1874 0.08 0.10 4.1874 0.09 0.10 42100 0.11 0.10 42100 0.20 0.90 42117 0.11 0.10 42101 0.11 0.10 42101 0.11 0.10 42101 0.11 0.10 42114 0.11 0.10 42114 0.11 0.10 42114 0.11 0.10 42114 0.11 0.10 42114 0.11 0.10 42114 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42210 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.11 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 42310 0.10 0.10 0.10 0.10 42310 0.10 0.10 0.10 0.10 42310 0.10 0.10 0.10 0.10 42310 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.	٨	Drainage of mouth lesion	5.14	7.65	5.61	0.14	060	41872	~	Repair gum	2.90	6.24	3.76	80.0	060
0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 4.00 A Derainage mouth roof lesion 1.23 2.71 1.43 0.00 0.00 0.00 0.00 4.00 A Bitpays roof of mouth 1.33 2.39 1.87 0.09 0.10 4.21(4) A Excision lesion, mouth roof 2.12 4.50 2.32 0.09 0.10 4.21(4) A Excision lesion, mouth roof 2.12 4.50 4.31 0.29 0.10 4.21(4) A Excision lesion, mouth roof 2.12 4.50 4.31 0.09 0.11 0.10 4.21(4) A Excision lesion, mouth roof 2.12 4.50 4.31 0.09 0.11 0.10 4.21(4) A Excision lesion, mouth roof 2.12 4.43 0.31 0.09 0.11 0.10 4.21(4) A Excision of routh 1.43 0.70 4.31 0.70 4.31 0.70	0.08 0110 41899 0.08 0101 42000 0.08 0101 42000 0.005 0101 42100 0.018 0900 42100 0.011 0100 42100 0.011 0100 42100 0.011 0100 42100 0.011 0100 42100 0.011 0100 42100 0.011 0100 42100 0.011 0000 42100 0.012 0900 42200 0.013 0900 42200 0.02 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.03 0900 42200 0.04 0900 42200 0.05 0900 0900 0900 42200 0.05 0900 0900 0900 42200 0.05 0900 0900 0900 0900 0900 0.05 0900 0900 0900 0900 0900 0900 0.05 0900 0900 0900 0900 0900 0900 0900	∀	Place needles h&n for rt	8.84	N.	3.66	0.55	000	41874	~	Repair tooth socket	3.13	5.87	3.20	0.10	060
010 47000 A Parininge mouth roof festor 1.23 2.91 1.43 0.08 0.06 010 42100 A Excision lesion, mouth roof 1.26 3.69 1.47 0.09 0.09 42104 A Excision lesion, mouth roof 1.17 7.00 4.31 0.29 0.14 0.90 42107 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.09 0.14 0.90 42107 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.09 0.14 0.90 42107 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.09 0.19 4.210 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.09 0.09 1.10 0.10 4.210 A Repair palse, pharyakovuela 9.63 1.81 1.33 1.11 1.93 1.11 1.93 1.11 1.93 1.11 1.94 0.11 1.	0.068 0110 42000 0.056 0101 42000 0.050 0101 42104 0.018 090 42104 0.019 090 42107 0.011 010 42104 0.011 010 42104 0.011 010 42104 0.011 010 42140 0.011 010 42140 0.011 010 42180 0.02 090 42180 0.03 090 42205 0.04 0205 0.05 090 42205 0.05 090 42205 0.06 090 42206 0.07 VYY 42300 0.08 090 42206 0.09 010 42206 0.00 000 42300 0.00 000 42300	¥	Biopsy of tongue	1.39	2.79	1.35	80.0	010	41899	Ü	Dental surgery procedure	0.00	0.00	00.00	0.00	YYY
0.00 42100 A Biopsy roof of mouth 1.33 2.39 1.43 0.07 0.00 42104 A Excision lesion, mouth roof 1.15 4.50 1.87 0.09 0.20 0.00 42107 A Excision lesion, mouth roof 2.12 4.50 2.32 0.09 0.41 0.00 42120 A Excision of mouth roof 2.12 4.50 2.32 0.09 0.41 0.00 42120 A Excision of mouth roof 2.12 4.83 0.09 1.38 1.38 0.13 0.09 0.11 0.10 42140 A Excision of mouth roof 2.12 4.83 0.06 1.31 0.09 1.38 0.13 0.09 1.38 0.14 0.11 0.09 1.38 0.14 0.11 0.11 0.00 1.13 0.11 0.11 0.00 1.13 0.11 0.11 0.00 0.11 0.11 0.00 0.11 0.11 0.00 0.11 0.11 0.00 0.11 0.11 0.00	0.006 0110 42100 0.009 0110 421004 0.009 0110 421004 0.0011 0110 42145 0.011 0110 42145 0.011 0110 42145 0.011 0110 42145 0.011 0110 42145 0.010 42180 0.021 090 42180 0.031 010 42205 0.032 090 42210 0.032 090 42210 0.032 090 42210 0.030 010 42205 0.030 010 42206 0.030 010 42206 0.030 010 42206 0.030 010 42206 0.030 010 42306 0.030 010 010 010 42306 0.030 010 010 010 010 010 010 010 010 010	¥	Biopsy of longue	1.44	2.79	1.38	80.0	010	42000	¥	Drainage mouth roof lesion	1.25	2.71	1.43	80.0	010
010 42104 A Excision lesion, mouth roof 116 3.69 187 0.09 024 090 42107 A Excision lesion, mouth roof 2.12 4.36 1.37 0.09 024 090 42107 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.29 0.11 010 42140 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.39 0.11 010 42140 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.39 0.11 010 42140 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.39 0.10 42140 A Recrision lesion, mouth roof 4.48 7.00 4.31 0.39 0.10 42140 A Repair palate 4.48 7.00 9.39 1.31 1.33 1.11 1.34 1.34 1.34 1.34 1.34 1.34 1.34 1.34 1.	0.09 010 42104 0.018 090 42104 0.018 090 42107 0.04 090 42107 0.04 090 42107 0.09 090 42145 0.01 010 42145 0.01 090 42180 0.29 090 42180 0.29 090 42206 0.29 090 42205 0.31 090 42205 0.32 090 42205 0.33 010 42205 0.34 090 42205 0.34 090 42205 0.35 010 42205 0.36 090 42280 0.37 010 42205 0.30 010 42207 0.30 010 42207 0.30 010 42207 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 010 42300 0.30 000 000 42330	Ą	Biopsy of floor of mouth	1.07	2.60	1.22	90'0	010	42100	Ą	Biopsy roof of mouth	1.33	2.39	1.43	0.07	010
0.00 42106 A Excision lesion, mouth roof 2.12 4.50 2.32 0.09 0.04 0.05 42107 A Recuision lesion, mouth roof 4.28 7.00 4.31 0.09 0.04 4210 A Rexision of varual 1.65 4.81 2.35 0.10 0.11 0.00 42140 A Repair palace planter of varual 1.65 4.81 2.35 0.09 1.53 0.00 4.2140 A Repair palace planter of varual 1.65 4.81 2.35 0.09 2.31 0.00 4.2140 A Repair palace planter of varual 1.65 4.80 0.19 0.11 2.34 0.00 4.2182 A Reconstruct of palace 1.84 4.74 2.31 0.16 2.34 0.00 4.2210 A Reconstruct of palace 1.24 NA 1.27 0.41 2.35 0.00 4.2210 A Reconstruct of palace 1.35 NA 1.27 0.94 1.12 2.35 0.00 4.2210 A	0.22 0.90 42106 0.22 0.90 42106 0.22 0.90 42107 0.01 0.00 42120 0.01 0.00 42145 0.01 0.00 42180 0.28 0.90 42180 0.28 0.90 42180 0.29 0.90 42180 0.29 0.90 42180 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42206 0.20 0.90 42226 0.20 0.90 0.42230 0.20 0.00 0.00 42390 0.00 0.00 0.42330 0.00 0.00 0.42330 0.00 0.00 0.42330 0.00 0.00 0.42330 0.00 0.00 0.42330	¥	Excision of tongue lesion	1.53	3.81	1.84	60'0	010	42104	٧	Excision lesion, mouth roof	1.66	3.69	1.87	60.0	010
0.00 4.2107 A Excision lesion, mouth roof 4.48 7.00 4.31 0.29 0.44 0.05 4.2120 A Remove palate/fesion 11.70 NA 13.87 1.13 0.19 0.00 4.2140 A Repair palate, plaryxukuvila 9.63 NA 1.94 0.16 1.53 0.00 4.2140 A Repair palate, plaryxukuvila 9.63 NA 1.94 0.16 2.37 0.00 4.2180 A Repair palate 1.82 4.00 1.94 0.16 2.81 0.00 4.2180 A Repair palate 1.24 NA 1.95 0.17 2.82 0.00 4.2200 A Reconstruct cleft palate 1.37 NA 2.29 0.05 2.82 0.00 4.2210 A Reconstruct cleft palate 1.34 NA 2.39 0.23 2.43 0.00 4.2210 A Reconstruct cleft palate 1.34 NA 2.39	020 090 42107 0344 090 42107 011 010 42140 0119 000 42140 0119 090 42140 0119 090 42180 027 090 42180 029 090 42180 029 090 42180 029 090 42205 020 090 42210 020 090 42210 020 090 42210 020 090 000 020 000 000 020 000 000 000 020 000 00	4	Excision of tongue lesion	2.77	5.42	3.52	0.18	060	42106	₹.	Excision lesion, mouth roof	2.12	4.50	2.32	60.0	010
0.04 0.09 42120 A Remove palate/fesion 11.70 NA 13.87 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 1.13 0.04 42144 A Excision of fuvula 1.15 4.81 2.35 0.15 0.04 1.14 0.11 1.13 0.04 0.04 1.14 0.11 4.01 1.94 0.11 1.14 0.04 1.94 0.11 1.25 0.35	0.064 0.90 42120 0.11 0.00 42140 0.11 0.00 42145 1.03 0.90 42145 1.03 0.90 42182 2.81 0.90 42205 2.81 0.90 42205 2.82 0.90 42205 2.83 0.90 42205 2.84 0.90 42205 2.85 0.90 42205 2.85 0.90 42205 2.86 0.90 42205 2.86 0.90 42205 2.86 0.90 42205 2.86 0.90 42205 2.87 0.90 42205 2.88 0.90 42205 2.89 0.90 42205 2.80 0.90 42205 2.80 0.90 42205 2.80 0.90 42205 2.80 0.90 42205 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42206 2.80 0.90 42300 2.80 0.90 0.90 42300 2.80 0.90 0.90 42300 2.8	٧	Excision of tongue lesion	3.23	5.75	3.77	0.20	060	42107	٧	Excision lesion, mouth roof	4.48	7.00	4.31	0.29	060
0.10 42140 A Excision of wula 165 481 235 0.16 0.10 990 42145 A Regair palate planytwids 9.63 NA 8.76 0.94 1.33 900 42180 A Texpair palate plantent of lesson 1.82 4.04 8.01 1.94 1.94 8.01 1.14 9.04 9.01 1.94 1.94 8.01 1.94 1.94 8.01 1.12 9.01 1.24 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.01 1.24 NA 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.21 9.06 1.22 9.01 1.22 9.01 1.21 9.01 1.21 9.01 1.21 9.01 1.21 9.01 1.21 9.01 1.21 9.02 9.01 1.21 9	0.011 0110 42140 0.019 090 42165 0.019 090 42166 0.153 090 42180 0.27 090 42180 0.281 090 42180 0.281 090 42180 0.282 090 42200 0.282 090 42200 0.283 090 42200 0.283 090 42200 0.284 090 42200 0.285 090 42220 0.286 090 42220 0.286 090 42280 0.286 090 42280 0.287 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 42280 0.280 090 000 000 000 000 000 000 000 000 0	٧	Excision of tongue lesion	8.71	NA	7.46	9.0	060	42120	٧	Remove palate/Jesion	11.70	NA	13.87	1.13	060
11.9 90.9 42145 A Repair palate, planyow/uvula 9.63 NA 8.76 0.94 1.3 90.9 42166 A Repair palate 1.82 4.00 1.94 0.11 2.5 90.9 42180 A Repair palate 3.84 4.54 2.31 0.16 2.8 90.9 42200 A Reconstruct cleft palate 1.241 NA 9.96 1.21 2.2 90.9 42200 A Reconstruct cleft palate 1.241 NA 1.29 0.04 2.2 90.9 42210 A Reconstruct cleft palate 1.49 NA 1.21 0.19 4.2 10.9 A Reconstruct cleft palate 1.69 NA 1.13 0.11 4.2 10.0 42220 A Reconstruct cleft palate 1.69 NA 1.13 0.11 2.5 10.1 42220 A Reconstruct cleft palate 1.69 NA 1.13 0.11 <td>1.19 090 42145 1.107 090 42145 1.107 090 42180 1.297 090 42180 2.297 090 42180 2.297 090 42180 2.297 090 42205 2.297 090 42205 2.297 090 42205 2.297 090 42225 2.297 090 42226 2.297 090 42226 2.297 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 090 090 42236 2.297 090 090 090 090 090 090 090 090 090 0</td> <td>4</td> <td>Excision of tongue fold</td> <td>1.76</td> <td>4.46</td> <td>2.17</td> <td>0.11</td> <td>010</td> <td>42140</td> <td>¥</td> <td>Excision of uvula</td> <td>1.65</td> <td>4.81</td> <td>2.35</td> <td>91.0</td> <td>060</td>	1.19 090 42145 1.107 090 42145 1.107 090 42180 1.297 090 42180 2.297 090 42180 2.297 090 42180 2.297 090 42205 2.297 090 42205 2.297 090 42205 2.297 090 42225 2.297 090 42226 2.297 090 42226 2.297 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 42236 2.297 090 090 090 090 090 090 42236 2.297 090 090 090 090 090 090 090 090 090 0	4	Excision of tongue fold	1.76	4.46	2.17	0.11	010	42140	¥	Excision of uvula	1.65	4.81	2.35	91.0	060
1,07 990 42160 A Treatment mouth roof lesion 182 4,00 194 011 1,53 990 42180 A Repair palate 2.52 3.82 2,31 0.16 2,81 090 42180 A Reconstruct cleft palate 12,41 NA 9.96 121 3,67 090 42200 A Reconstruct cleft palate 12,41 NA 9.96 121 3,24 090 42210 A Reconstruct cleft palate 8.88 NA 9.96 121 3,24 090 42210 A Reconstruct cleft palate 8.88 NA 8.01 1.33 3,15 010 42220 A Reconstruct cleft palate 8.88 NA 8.01 1.33 3,15 010 42220 A Reconstruct cleft palate 8.88 NA 8.01 1.33 3,15 010 42220 A Reconstruct cleft palate 8.88 NA 8.01 </td <td>1.07 090 42160 1.53 090 42180 1.53 090 42180 2.81 090 42180 2.81 090 42205 3.67 090 42210 3.24 090 42215 3.24 090 42215 3.24 090 42215 3.24 090 42225 3.25 010 42226 3.26 090 42227 3.26 010 42226 3.27 010 4229 3.28 010 4239 3.29 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239</td> <td>∢</td> <td>Excision of mouth lesion</td> <td>2.47</td> <td>5.72</td> <td>3.08</td> <td>0.19</td> <td>060</td> <td>42145</td> <td>Ą</td> <td>Repair palate, pharynx/uvula</td> <td>9.63</td> <td>Ϋ́</td> <td>8.76</td> <td>0.94</td> <td>060</td>	1.07 090 42160 1.53 090 42180 1.53 090 42180 2.81 090 42180 2.81 090 42205 3.67 090 42210 3.24 090 42215 3.24 090 42215 3.24 090 42215 3.24 090 42225 3.25 010 42226 3.26 090 42227 3.26 010 42226 3.27 010 4229 3.28 010 4239 3.29 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239 3.20 010 4239	∢	Excision of mouth lesion	2.47	5.72	3.08	0.19	060	42145	Ą	Repair palate, pharynx/uvula	9.63	Ϋ́	8.76	0.94	060
1.53 090 42180 A Repair palate 2.25 3.82 2.31 0.16 2.87 090 42182 A Repair palate 12.41 NA 2.99 0.15 2.81 090 42200 A Reconstruct cleft palate 13.57 NA 9.96 1.21 3.24 090 42210 A Reconstruct cleft palate 14.91 NA 1.21 0.04 2.38 090 42215 A Reconstruct cleft palate 14.91 NA 1.21 0.04 2.38 090 42220 A Reconstruct cleft palate 14.91 NA 1.31 0.19 2.38 090 42220 A Reconstruct cleft palate 1.07 NA 1.31 0.19 2.36 010 42220 A Reconstruct cleft palate 1.07 NA 1.30 0.19 2.36 010 42220 A Repair palate 1.07 NA 1.30 0.	153 090 42180 281 090 42180 281 090 42182 281 090 42200 282 090 42200 232 090 42210 234 090 42215 238 010 42225 239 090 42225 238 010 42226 239 090 42280 238 090 42280 239 010 42280 230 010 42280 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390 230 010 42390	∢	Partial removal of tongue	16.91	ΥN	15.84	1.07	060	42160	٧	Treatment mouth roof lesion	1.82	4.00	1.94	0.11	010
2.97 090 42182 A Repair palate 3.84 4.54 2.93 0.25 2.87 090 42200 A Reconstruct cleft palate 1.241 NA 9.96 1.21 2.92 090 42205 A Reconstruct cleft palate 1.491 NA 9.88 1.32 2.92 090 42215 A Reconstruct cleft palate 1.491 NA 1.279 0.41 2.32 090 42225 A Reconstruct cleft palate 9.66 NA 1.31 0.41 2.38 010 42225 A Reconstruct cleft palate 9.66 NA 1.316 0.94 2.36 090 42225 A Reconstruct cleft palate 9.66 NA 1.316 0.94 2.36 010 42226 A Lengthening of palate 1.07 NA 1.316 0.94 2.34 010 42227 A Lengthening of palate 1.02 NA 1.115 0.77 2.34 090 42228 A Repair palate	2.97 090 42182 2.81 090 42200 2.81 090 42200 2.92 090 42200 2.92 090 42201 2.93 090 42201 2.93 010 42225 2.93 010 42226 2.93 010 42226 2.93 090 62226 2.93 090 62229 2.93 090 62239 2.93 010 62239 2.93 010 62239 2.93 010 62330 2.93 010 62300 2.93 0	٧	Partial removal of tongue	15.51	NA	17.93	1.53	060	42180	¥	Repair palate	2.52	3.82	2.31	91.0	010
2.81 090 42200 A Reconstruct cleft palate 12.41 NA 9.96 12.1 2.92 090 42205 A Reconstruct cleft palate 1.3.7 NA 9.98 1.2.1 2.34 090 42215 A Reconstruct cleft palate 8.88 NA 9.01 1.3.7 1.38 090 42225 A Reconstruct cleft palate 9.66 NA 1.1.3 0.04 2.35 010 42225 A Reconstruct cleft palate 9.66 NA 1.3.16 0.94 2.36 010 42225 A Reconstruct cleft palate 9.66 NA 1.3.16 0.94 2.36 010 42226 A Reconstruct cleft palate 9.66 NA 1.3.16 0.94 2.36 010 42227 A Lengtherning of palate 9.66 NA 1.1.15 0.00 2.34 090 42227 A Repair palate 9.88 NA 1.1.15 0.72 2.34 090 42228 A Repair palate	2.81 090 42200 2.84 090 42200 2.85 090 42210 2.82 090 42210 2.82 090 42210 2.83 090 42220 2.84 090 42220 2.85 010 42220 2.85 090 42220 2.85 090 42220 2.85 090 42280 2.85 0	¥	Tongue and neck surgery	29.83	NA	26.03	2.97	060	42182	¥	Repair palate	3.84	4.54	2.93	0.25	010
5.67 090 42205 A Reconstruct cleft plate 13.57 NA 9.88 1.32 2.34 090 42216 A Reconstruct cleft plate 14.91 NA 12.19 0.41 4.28 090 42215 A Reconstruct cleft plate 8.88 NA 13.1 0.19 4.28 010 42225 A Reconstruct cleft plate 8.88 NA 13.1 0.19 2.56 010 42225 A Reconstruct cleft plate 9.66 NA 13.10 0.19 2.56 010 42225 A Repair plate 9.81 NA 13.02 1.00 2.56 090 42226 A Repair plate 7.92 NA 12.04 0.96 2.54 090 42226 A Repair plate 7.92 NA 11.15 0.77 2.54 0.90 42280 A Repair plate 7.92 NA 11.15 0.74	8.67 090 42205 3.24 090 42210 3.24 090 42210 3.24 090 42210 3.25 090 42210 3.25 090 42225 3.26 090 42225 3.26 010 42226 3.26 010 42226 3.26 090 42280 3.23 010 42280 3.23 010 4229 3.00 000 42390 3.00 000 42390 3.00 000 42330 3.00 000 42330 3.00 000 42330 3.00 000 42330 3.00 000 42330	٧	Removal of tongue	28.81	NA	27.91	2.81	060	42200	¥	Reconstruct cleft palate	12.41	NA	96.6	121	060
2.9.2 0.90 42210 A Reconstruct cleft palate 14.91 NA 12.79 0.41 3.2.8 0.90 42215 A Reconstruct cleft palate 8.88 NA 8.11 0.19 2.18 0.10 42225 A Reconstruct cleft palate 9.66 NA 13.16 0.94 2.15 0.10 42225 A Lengthening of palate 10.24 NA 13.16 0.94 3.36 0.90 42225 A Lengthening of palate 10.24 NA 13.16 0.94 3.34 0.90 42225 A Repair palate 10.24 NA 13.16 0.77 0.34 0.90 42228 A Repair palate 1.92 NA 11.15 0.77 0.38 0.90 42280 A Repair palate 1.92 NA 11.15 0.77 0.38 0.90 42280 A Repair palate 1.92 NA 11.15 0.	2.22 0.90 4210 42216 428 0.90 42225 1.18 0.10 42226 1.26 0.10 42226 2.26 0.10 42227 2.34 0.90 4228 2.34 0.90 4228 2.35 0.10 4228 2.30 0.10 42280 2.30 0.10 42280 2.30 0.10 42290 2.30 0.10 42390 2.30 0.10 62390 2.30	∢	Tongue removal, neck surgery	37.59	NA	34.38	3.67	060	42205	٧	Reconstruct cleft palate	13.57	NA NA	88.6	1.32	060
134 090 42215 A Reconstruct cleft palate 8.88 NA 8.01 133 428 090 42220 A Reconstruct cleft palate 7.07 NA 5.11 0.09 3.18 010 42225 A Lengthering of palate 9.66 NA 13.16 0.94 3.26 010 42225 A Lengthering of palate 9.66 NA 13.02 1.00 3.24 090 42226 A Repair palate 9.81 NA 11.15 0.77 3.34 090 42226 A Repair palate post post palate 10.10 11.07 7.27 0.98 3.35 090 42280 A Repair post post palate	13.4 090 42215 4228 090 42220 13.8 010 42222 13.6 010 42222 13.6 090 42223 13.6 090 42235 13.9 010 4229 13.0 010 4239 13.0 010 4239 13.0 010 4239 13.0 010 4239 13.0 010 4239 14.0 000 4239 15.0 010 4230 15.0 010 4230 15.0 010 4230 15.0 010 4230 15.0 010 4230 16.0 000 4233 16.0 000 4233	4	Tongue, mouth, jaw surgery	29.52	NA	27.27	2.92	060	42210	¥	Reconstruct cleft palate	14.91	ΝA	12.79	0.41	060
4.22.9 A Reconstruct cleft palate 7.07 NA 5.11 0.19 5.15 010 42225 A Lengthening of palate 9.66 NA 13.10 0.19 5.26 010 42225 A Lengthening of palate 9.81 NA 13.02 1.00 5.36 090 42227 A Repair palate 9.81 NA 12.04 0.96 5.36 090 42226 A Repair nose to life fixula 1.010 1.115 0.77 0.88 5.36 090 42280 A Repair nose to life fixula 1.56 2.59 1.29 0.04 5.08 090 42280 A Repair nose to life fixula 1.56 2.59 1.29 0.04 5.09 42280 A Berair nose to life fixula 1.56 2.59 1.20 0.01 5.01 42280 A Balacivurus gatenet 1.56 3.36 2.01 0.11 5.02 101 42230 A Drainage of salivary gland 1.55 3.59 1.56	4.28 090 4220 4.28 010 42225 5.15 010 42225 5.26 010 42227 5.26 010 42227 5.34 090 42235 5.34 090 42280 5.33 010 4229 5.00 07 YYY 4230 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 4239 5.00 010 6239 5.00 01	A	Tongue, mouth, neck surgery	33.28	X.	28.68	3.24	060	42215	Ą	Reconstruct cleft palate	8.88	NA NA	8.01	133	060
9.18 010 42225 A Reconstruct cleft palate 9.66 NA 13.16 0.94 0.16 42226 A Lengthening of palate 10.24 NA 13.16 0.94 0.36 010 42227 A Repair nose to lip fistula 10.24 NA 13.04 0.96 0.34 090 42236 A Repair nose to lip fistula 10.10 11.07 7.27 0.88 0.90 42280 A Preparation palate model 1.56 2.59 1.29 0.04 0.09 42280 A Preparation palate model 1.56 2.59 1.29 0.04 0.09 42280 A Insertion palate model 1.56 2.59 1.29 0.04 0.09 42280 A Insertion palate model 1.56 2.59 1.29 0.04 0.09 42280 A Insertion palate models 1.56 3.41 2.00 0.00 0.09 42280 A Drainage of salivary gland 1.53 3.41 2.00 0.10 0	1.18 010 42225 2.26 010 42226 2.26 010 42226 2.34 090 42236 2.34 090 42280 2.35 090 42280 2.30 010 42280 2.30 010 42290 2.30 010 42390 2.30 010 42390 2.30 010 42390 2.30 000 000 42330 2.30 000 62230 2.30 000 62230 2.30 000 62230 2.30 000 62230 2.30 000 62330 2.30 000 622300 2.30 000 622300 2.30 000 622300 2.30 000 622300 2.30 000 622300 2.30 000 622300 2.30 000 62	¥	Tongue, jaw, & neck surgery	43.96	NA	33.50	4.28	060	42220	4	Reconstruct cleft palate	7.07	NA	5.11	0.19	060
1,5 0.10 4,2226	13.5 010 42226 13.2 010 42227 13.6 090 42280 13.3 090 42280 13.3 090 42280 13.3 010 42281 13.3 010 42281 13.0 010 42281 13.0 010 42391 13.0 010 42392 13.0 010 42310 13.0 010 42310 13.0 010 42310 13.0 010 42310 14.0 010 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 42310 15.0 010 14.0 14.0 14.0 14.0 14.0 14.0 14.	4	Repair tongue laceration	1.93	4.46	1.92	0.18	010	42225	Ą	Reconstruct cleft palate	99.6	K K	13.16	0.94	060
2.26 010 42227 A Lengthening of palate 9.81 NA 12.04 0.96 3.34 090 42235 A Repair palate 7,92 NA 11.07 2.77 0.98 3.36 090 42280 A Preparation, palate mold 1.56 2.59 1.29 0.04 0.08 090 42280 A Insertion, palate mold 1.56 2.59 1.29 0.04 0.09 42280 A Disertion, palate mold 1.56 2.59 1.29 0.04 0.00 42281 A Insertion, palate mosthesis 1.95 3.36 2.01 0.13 0.00 42281 A Disertion, palate mosthesis 1.95 3.36 2.01 0.13 0.00 42281 A Disertion, palate prosthesis 1.95 3.46 2.00 0.00 0.01 42299 C Palate/uvuls surger 6.23 NA 4.96 0.59 0.02 42290 A Drainage of salivary gland 1.55 1.66 0.10 0.14	0.256 010 42227 0.256 090 42227 0.34 090 42280 0.356 090 42280 0.357 010 42290 0.358 010 42290 0.359 010 42290 0.307 010 42230 0.307 010 42230 0.307 010 42230 0.307 010 42230 0.307 010 42230 0.307 010 42230 0.307 010 42230 0.307 010 62230	¥	Repair tongue laceration	2.29	4.65	2.15	0.15	010	42226	٧	Lengthening of palate	10.24	NA NA	13.02	00:1	060
3.36 090 42235 A Repair palate 7,92 NA 11.15 0,77 3.34 090 42260 A Preparations to lip fixtula 10,10 11.07 7,27 0.98 3.08 090 42281 A Insertion, palate mold 1,56 2.59 1.29 0.04 2.08 090 42281 A Insertion, palate mold 1,56 3.36 2.01 0.13 0.09 42289 C Palate/uvuls surgery 0.00 0.00 0.00 0.00 0.97 VYY 42300 A Drainage of salivary gland 6.23 3.41 2.00 0.14 0.09 0.10 42310 A Drainage of salivary gland 6.23 NA 4.96 0.59 0.00 42230 A Drainage of salivary gland 1.35 2.59 1.66 0.10 0.01 42230 A Drainage of salivary gland 1.35 2.59 1.66 0.10 0.00 42230 A Removal of salivary gland 1.38 2.59 1.66 </td <td>0.36 0.90 42235 0.34 0.90 42236 0.36 0.90 42280 0.36 0.90 42280 0.32 0.10 42281 0.33 0.10 4239 0.00 0.10 42310 0.30 0.10 42310 0.30 0.10 42310 0.30 0.00 42330 0.30 0.00 42330 0.30 0.00 62330 0.30 0.00 0.00 62330 0.30 0.00 0.00 62330</td> <td>₹</td> <td>Repair tongue laceration</td> <td>2.99</td> <td>5.05</td> <td>2.49</td> <td>0.26</td> <td>010</td> <td>42227</td> <td>A</td> <td>Lengthening of palate</td> <td>9.81</td> <td>۲ Z</td> <td>12.04</td> <td>96.0</td> <td>060</td>	0.36 0.90 42235 0.34 0.90 42236 0.36 0.90 42280 0.36 0.90 42280 0.32 0.10 42281 0.33 0.10 4239 0.00 0.10 42310 0.30 0.10 42310 0.30 0.10 42310 0.30 0.00 42330 0.30 0.00 42330 0.30 0.00 62330 0.30 0.00 0.00 62330 0.30 0.00 0.00 62330	₹	Repair tongue laceration	2.99	5.05	2.49	0.26	010	42227	A	Lengthening of palate	9.81	۲ Z	12.04	96.0	060
3.34 090 42260 A Repair nose to ligh fistula 10.10 11.07 7.27 0.58 0.36 090 42280 A Preparation, palate noted 1.56 2.39 1.29 0.04 0.08 090 42281 A Insertion, palate noted 1.56 2.91 1.31 0.04 0.09 42299 C Palate/tuvula surgery 0.00 0.14 0.10 1.14 2.00 0.10 1.01 1.01 1.01 1.01 1.01 1.01 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00<	13.4 090 42260 13.6 090 42280 10.8 090 42281 10.0 42281 10.0 10.0 42291 10.0 000 42310 10.0 000 42330 10.0 000 42330 10.0 000 42330 10.0 000 42330 10.0 000 42330 10.0 000 42330	K	Fixation of tongue	3.74	NA	8.04	0.36	060	42235	4	Repair palate	7.92	ΥZ	11.15	0.77	060
1.56 0.90 4.2280	136 090 42280 1008 090 42280 1033 010 42299 1009 110 42309 100 000 42300 100 000 42300 100 000 42300 100 000 42300 100 000 100 100 100 000 100 100 100 000 100 1	٧	Tongue to lip surgery	3.45	NA	7.30	0.34	060	42260	Y	Repair nose to lip fistula	10.10	11.07	7.27	86.0	060
0.08 0.90 42281 A luserrion, palate prosthesis 1.95 3.36 2.01 0.13 0.02 YYY 42299 C Pattaletivula sugery 0.00 0.00 0.00 0.03 YYY 42309 A Drainage of salivary gland 6.23 NA 4.96 0.59 0.04 42310 A Drainage of salivary gland 6.23 NA 4.96 0.59 0.05 0.00 42330 A Drainage of salivary gland 1.38 2.59 1.66 0.10 0.07 42330 A Drainage of salivary gland 2.23 4.86 0.10 0.09 42330 A Removal of salivary gland 2.23 3.68 2.04 0.13 0.00 42330 A Removal of salivary stone 3.35 6.15 3.30 0.29 0.00 42330 A Removal of salivary stone 3.35 6.15 3.30 0.29 0.00 42330 A Removal of salivary stone 3.35 6.15 3.30 0.29 0.00	0.08 090 42281 0.23 010 4229 0.00 YYY 42390 0.00 YYYY 42300 0.00 010 42310 0.00 000 42330 0.00 000 42330 0.00 000 62330 0.00 000 62330 0.00 000 000 42330 0.00 000 000 000 000 0.00 000 000 000	₹	Tongue suspension	6.75	ΝΆ	0.70	0.36	060	42280	¥	Preparation, palate mold	1.56	2.59	1.29	0.04	010
0.10 42399 C Palate/uvula surgery 0.00 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 0.10 <td>2.33 010 42299 2.00 YYY 4300 2.00 010 42305 2.00 000 42330 2.00 000 42330 2.00 000 42330 2.00 000 600 600 2.</td> <td>∢</td> <td>Reconstruction, tongue fold</td> <td>2.77</td> <td>6.12</td> <td>3.82</td> <td>80:0</td> <td>060</td> <td>42281</td> <td>¥</td> <td>Insertion, palate prosthesis</td> <td>1.95</td> <td>3.36</td> <td>2.01</td> <td>0.13</td> <td>010</td>	2.33 010 42299 2.00 YYY 4300 2.00 010 42305 2.00 000 42330 2.00 000 42330 2.00 000 42330 2.00 000 600 600 2.	∢	Reconstruction, tongue fold	2.77	6.12	3.82	80:0	060	42281	¥	Insertion, palate prosthesis	1.95	3.36	2.01	0.13	010
1,000 YYY 42300	0.00 YYY 4250 0.09 010 42310 0.03 010 42310 0.00 000 42330 0.00 000 42330 1.00 000 62330 1.00 000 6230 1.00 000 6230 1.00 000 6230 1.00 000 6230 1.00 000 6230 1.00 000 6230 1.00	4	Tongue base vol reduction	4.38	74.78	6.07	0.23	010	42299	ပ	Palate/uvula surgery	0.00	0.00	0.00	0.00	λ.
100 101 102 102 103	0.09 010 42305 0.03 010 42310 0.00 000 42330 0.00 000 42330 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	O	Tongue and mouth surgery	0.00	0.00	0.00	0.00	YYY	42300	∢	Drainage of salivary gland	1.95	3.41	2.00	0.14	010
1.58 2.59 1.66 0.10 1.58 2.59 1.66 0.10 1.59 0.10 4.2120	0.03 0.10 42.110 0.04 0.10 42.320 0.00 0.00 42.335 1 0.00 0.00 42.335 1 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 0.00 0.00 1 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	∢	Drainage of gum lesion	1.21	5.18	2.34	60:0	010	42305	٧	Drainage of salivary gland	6.23	ΑX	4.96	0.59	060
1,20	0.07 010 4.2320 0.00 0.00 4.2330 0.00 0.00 4.2335 1 F F F F F F F F F F F F F F F F F F F	¥	Removal foreign body, gum	1.28	4.84	2.99	0.03	010	42310	٧	Drainage of salivary gland	1.58	2.59	1.66	0.10	010
2.23 3.68 2.04 0.13	0.00 0.00 4.2330 0.00 0.00 4.2335 1. F.	¥	Removal foreign body,jawbone	2.73	6.19	3.92	0.07	010	42320	٧	Drainage of salivary gland	2.37	4.10	2.24	0.15	010
1.20 0.00 4.2335 A Removal of salivary stone 3.35 6.15 3.30 0.29 **CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. **The Values are reflected for codes not payable by Medicare, please note that these values have been established as a courtery to the general public and are not used for Medicare payment. **The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the Riles used for Medicare payment. **Clobal Index Payament of the CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the Riles used for Albeitane payment. **Clobal Index Payament of the CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the Riles used for Albeitane payment. **Clobal Index Payament of the CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the Riles used for Albeitane Payament.	0.00 000 42335 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	œ	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	000	42330	¥	Removal of salivary stone	2.23	3.68	2.04	0.13	010
for CPT 3	for CPT 5	ಜ	Excision of gum flap	00.0	0.00	0.00	00:0	000		٧	Removal of salivary stone	3.35	6.15	3.30	0.29	060
for CPT 5	for CPT	es and	descriptions only are copyright 2009 ι	smerican Medi	cal Associat	ion. All Rig	bts		CPT cod	les and de	escriptions only are copyright 2009	American Med	lical Associati	ion. All Rigl	ts	
for CPT c	for CPT 5	376	Rected for codes not payable by Medic	are, please not	that these v	alues have h	cen		Keserved. 2 If values	are refle	cted for codes not payable by Medic	are, please no	te that these v	afnes have b	G	
tor CPT	for CPT	lasa	courtesy to the general public and are n	ot used for Me	dicare paym	ent.			establishe	dasaco	artesy to the general public and are n	ot used for M	edicare payme	ent.		
na bractice RVI is may not our due to rounding	n alpractice RVUs may not sum due to rounding.	et net 0,98	itrality reduction from the chiropractic 341, and 98942. The required reduction	demonstration n will only be	is not reflect effected in t	ed in the RV he files used	Us for CPT for		The bud codes 989	get neutra 40, 9894	alty reduction from the chiropractic 1, and 98942. The required reduction	demonstration n will only be	is not reflect reflected in th	ted in the RV he files used	Us for CPT for	
		ayme	pt.	o il					Medicare	payment	naturaction DAG to man and man due	ouipanos o				

Reserved.

The first alless are reflected for codes not payable by Medicare, please note that these values have been established as a courrey to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 9840, 98841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice R VUs may not sum due to rounding.

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been a first values are reflected for codes not payable by Medicare payament.

If values are reflected for codes not payable by Medicare payment.

The budger neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

CPT ^{c,}	2	1	Dancrinkim	Physician Cian Work RVija ^{2 3}	Non- Facility PE RVUs ^{2,3}	Facility PE RVUs ^{2,3}	Mal- Practice RVUs ^{2 3,4}	Global	CPT ⁽³⁾ HCPCS	Mod	Status	Deacrition	Physi- clan Work RVIu ^{2,3}	Non- Facility PE RVUs ^{2,3}	Facility PE RVUs ^{2,3}	Mal- Prectice RVUs ^{2,3,4}	Global
43107		∢	Removal of esophagus	43.97	NA	19.73	7.46	060	43247		Ĭ	Operative upper GI endoscopy	3.38	NA	1.73	0.27	000
43108		٧	Removal of esophagus	82.66	NA	34.36	14.69	060	43248		N V	Uppr gi endoscopy/guide wire	3.15	Z Z	1.65	0.22	000
43112		∢	Removal of esophagus	47.27	NA	20.04	8.11	060	43249	•	¥ Eŭ	Esoph endoscopy, dilation	2.90	ΝA	1.54	0.21	000
43113		<	Removal of esophagus	79.85	NA	34.53	12.93	060	43250	•		Upper GI endoscopy/tumor	3.20	NA V	1.63	0.29	000
43116		∢	Partial removal of esophagus	92.78	NA	46.78	9.05	060	43251	٠,	-	Operative upper GI endoscopy	3.69	Y.	1.87	0.28	000
43117		٧	Partial removal of esophagus	43.52	NA	18.36	7.46	060	43255	•		Operative upper GI endoscopy	4.81	NA	2.38	0.34	000
43118		¥	Partial removal of esophagus	98.99	Ϋ́	23,77	10,83	060	43256	4,	_	Uppr gi endoscopy w/stent	4.34	NA V	2.13	0.35	000
43121		K	Partial removal of esophagus	51.22	NA	20.07	9.10	060	43257	•		Uppr gi scope w/thrml txmnt	5.50	ΝA	2.76	0.37	9
43122		∢	Partial removal of esophagus	43.97	¥	20.13	7.28	060	43258	•	0 . V	Operative upper GI endoscopy	4.54	Y.	2.25	0.33	000
43123		∢	Partial removal of esophagus	82.91	NA	35.67	13.43	060	43259	4		Endoscopic ultrasound exam	5.19	N V	2.55	0.36	000
43124		V	Removal of esophagus	68.83	ΝĄ	26.18	12.23	060	43260	•	_	Eudo cholangiopancreatograph	5.95	ΥN	2.88	0.4	000
43130		<	Removal of esophagus pouch	12.41	Ϋ́	7.99	1.50	060	43261	•	_	Endo cholangiopancreatograph	6.26	ΥN	3.02	0.43	000
43135		∀	Removal of esophagus pouch	26.09	ΝΆ	11.37	4.51	060	43262	۹.	A	Endo cholangiopancreatograph	7.38	ΑN	3.52	0.51	000
43200		<	Esophagus endoscopy	1.59	3.81	- 12	0.12	000	43263	4	_	Endo cholangiopancreatograph	7.28	NA	3.44	0.50	000
43201		4	Esoph scope w/submucous inj	5.09	5.19	1.20	0.15	000	43264	4	A E	Endo cholangiopancreatograph	8.89	NA	4.19	19:0	00
43202		4	Esophagus endoscopy, biopsy	1.89	5.12	80.1	0.15	000	43265	٩.	_	Endo cholangiopancreatograph	10.00	K K	4.68	69.0	000
43204		V	Esoph scope w/sclerosis inj	3.76	NA	1.92	0.29	000	43267	•		Endo cholangiopancreatograph	7.38	NA	3.50	0.51	000
43205		Ą	Esophagus endoscopy/ligation	3.78	Ϋ́	1.92	0.27	000	43268	•	A E	Endo cholangiopancreatograph	7.38	Υ.	3.65	0.51	000
4320F			Pt talk psychsoc+rx ob dpnd	0.00	0.00	0.00	0.00	XXX	43269	٩.		Endo cholangiopancreatograph	8.20	NA	3.88	0.57	000
43215		4	Esophagus endoscopy	2.60	Ν	1.37	0.24	000	43271	•		Endo cholangiopancreatograph	7.38	¥Z	3.51	0.51	000
43216		∢	Esophagus endoscopy/lesion	2.40	3.06	1.30	0.24	000	43272	•	_	Endo cholangiopancreatograph	7.38	NA	3.53	0.50	000
43217		٧	Esophagus endoscopy	2.90	6.41	1.48	0.28	000	43273	•	_	Endoscopic pancreatoscopy	2.24	NA	0.98	0.15	222
43219		¥	Esophagus endoscopy	2.80	NA	1.54	0.27	000	43279	•	Υ Υ	ap myotomy, heller	22.00	ΥN	10.46	3.55	060
43220		∢	Esoph endoscopy, dilation	2.10	ΥN	1.18	0.17	000	43280	4	_	aparoscopy, fundoplasty	18:00	ΥN	8.95	2.90	060
43226		٧	Esoph endoscopy, dilation	2.34	NA	1.27	0.20	000	43289	0	_	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	λλ. λ
43227		∢	Esoph endoscopy, repair	3.59	NA	1.80	0.28	000	43300	•	_	Repair of esophagus	9.21	N.	6.95	0.90	060
43228		∢	Esoph endoscopy, ablation	3.76	NA NA	06.1	0.29	000	43305	•	Y.	Repair esophagus and fistula	17.98	V.	10.94	1.75	060
43231		∢ ·	Esoph endoscopy w/us exam	3.19	₹, ;	50.	0.24	000	43310			Repair of esophagus	26.18	K :	0.1.70	4.65	060
43232		< ⋅	Esoph endoscopy w/us in bx	4.47	V.	2.17	0.36	000	43312	٠, ٠		Repair esophagus and fistula	29.23	Z :	10.70	5.19	060
43234		∢ .	Upper GI endoscopy, exam	2.01	9.5	8 6	070	000	43313			sophagoplasty congenital	48.17	ď;	19.80	7.58	260
43235		∢ •	Uppr gi endoscopy, diagnosis	2.39	08.4	06.1	9.19	000	43314	۹, ۹		racheo-esophagopiasty cong	23.13	e s	79.97	2.5	26
43236		∢ <	Uppr gi scope w/submuc mj	76.7 00 c	0.50	502	170	000	43320	< <		ruse esophagus & stomach	37.66	4 4 2 2	10.00	3.75	8 8
43237		₹ <	Hard of the stant, esopu	3.98	¥ ×	3.5	0.29	000	43324	ι, «		Sevise esopuagus & siomach	22.47	5 × 2	10.70	3.70	260
43230		< 4	Uppi gi endoscopy w/us ni ox Umer Gl endoscopy bionsy	2.02	C 5	15.1	0.30	000	43524	< ∢	_	Nevise esopiagus of stomach	22.15	S Z	10.96	3.83	960
43240		: ∢	Esoph endoscope w/drain cvst	6.85	×	3.26	0.49	000	43330	. ≺		Repair of esophagus	22.06	Y.Y	10.70	3.61	060
43241		⋖	Upper GI endoscopy with tube	2.59	NA	1.39	0.21	000	43331	•	_	Repair of esophagus	22.93	NA	10.46	4.07	060
43242		Ą	Uppr gi endoscopy w/us fn bx	7.30	NA	3.48	0.50	000	43340	•	4	use esophagus & intestine	22.86	A'X	11.33	3.70	060
43243		4	Upper gi endoscopy & inject	4,56	NA	2.26	0.33	000	43341	•	ű,	use esophagus & intestine	24.10	ΑN	12.72	3.90	060
43244		4	Upper GI endoscopy/ligation	5.04	NA	2.49	0.35	000	43350	•	Š	Surgical opening, esophagus	19.31	NA	10.59	3.13	060
43245		٧	Uppr gi scope dilate strictr	3.18	NA	1.62	0.27	000	43351	•	Š.	Surgical opening, esophagus	21.87	NA	10.84	3.89	060
43246		4	Place gastrostomy tube	4.32	NA NA	2.10	0.39	000	43352	•	รั	Surgical opening, esophagus	17.68	ΥX	8.86	3.14	060
	CPTC	odes and	¹ CPT codes and descriptions only are copyright 2009 American Medical	merican Med	ical Associa	Association. All Rights	ghts		-	CPT codes	and des	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Med	ical Associa	tion. All Ri	shts	
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	establish	hed as a c	it values are refrected for cours not payable by victoring to private not used for Medicare payment established as a courtesy to the general public and are not used for Medicare payment	of used for Me	dicare payn	ratics nave lent.			6	stablished a	S a court	stablished as a courtesy to the general public and are not used for Medicare payment.	t used for Me	edicare payo	vallets liave	n n	
	The bu	adget neu	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 00041 and 00041. The sequenced reduction will only be reflected in the files used for	demonstration	is not reflec	ted in the R	VUs for CPT		m (The budget	neutrali 08041	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 08040, 08041, and 08042. The committed reduction will code be self-coded in the files used for	emonstration	is not reflect	eted in the R	VUs for CPT	
	Medicar	Medicare payment	MI.	and frame of		acr cours are			. ~	Medicare payment	ment.	management and a second	and income		The same		
	4 Global	l totals fo	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.					*	Global tota	ls for ma	Global totals for malpractice RVUs may not sum due to rounding.	rounding.				

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CPT ¹³ ,				Physi- clan Work	Non- Facility PE	Facility PE	Mat- Practice		CPT ^{1,3} /			Physi- clan Work	Non- Facility PE	Facility PE	Mat- Practice	
HCPCS	Mod	Status	_	RVU8 ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,4,4}	Global	'n	Mod Status		RVUs*	RVUs"	RVUs"	RVUe - 7	Š >
43360		∢	Gastrointestinal repair	39.90	V.	16.26	7.09	060	43659	ပ	_	0.00	0.00	0.00	0.00	۰ -
43361		¥	Gastrointestinal repair	45.50	NA	21.43	7.37	060	43752	¥	Nasal/orogastric w/stent	0.81	Y.	0.26	90'0	0
43400		×	Ligate esophagus veins	25.47	AN	13.81	2.84	060	43760	¥	Change gastrostomy tube	06.0	10.44	0.34	60.0	0
43401		٧	Esophagus surgery for veins	26.36	NA	12.63	4.27	060	43761	≺	Reposition gastrostomy tube	2.01	10.1	89.0	91.0	•
43405		٧	Ligate/staple esophagus	24.55	N'A	13.65	3.98	060	43770	⋖	Lap place gastr adj device	17.85	Y.	9.92	2.87	0 '
43410		∢	Repair esophagus wound	16.28	V.	8.43	2.89	060	43771	ď	Lap revise gastr adj device	20.64	۷ N	0.1	3.34	٠ (
43415		٧	Repair esophagus wound	28.70	N N	14.26	4.96	060	43772	¥	Lap rmvl gastr adj device	15.62	ΥN	8.11	2.53	0
43420		¥	Repair esophagus opening	16.65	NA	10.29	1.62	060	43773	¥	Lap replace gastr adj device	20.64	N A	10.1	3.34	0
43425		A	Repair esophagus opening	24.91	NA	13.02	4.03	060	43774	¥	Lap rmvl gastr adj all parts	15.66	X A	8.22	2.53	0
43450		¥	Dilate esophagus	1.38	2.41	0.87	0.10	000	43800	₹	Reconstruction of pylorus	15.35	NA	7.82	2.49	0
43453		Ą	Dilate esophagus	1.51	5.53	0.93	0.11	000	43810	¥	Fusion of stomach and bowel	16.80	NA	8.47	2.72	0
43456		V	Dilate esophagus	2.57	11.65	1.39	0.19	000	43820	∢	Fusion of stomach and bowel	22.40	NA	10.98	3.59	0
43458		٧	Dilate esophagus	3.06	6.42	1.60	0.23	000	43825	¥	Fusion of stomach and bowel	21.63	NA	10.73	3.50	0
43460		*	Pressure treatment esophagus	3.79	NA	1.94	0.26	000	43830	V	Place gastrostomy tube	10.75	Z Z	6.62	1.68	0
43496		O	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	060	43831	V	Place gastrostomy tube	8.38	NA V	6.29	1.36	0
43499		U	Esophagus surgery procedure	0.00	0.00	0.00	0.00	YYY	43832	¥	_	17.26	NA	8.96	2.71	0
43500		V	Surgical opening of stomach	12.71	ΝA	6.81	2.01	060	43840	∢	Repair of stomach lesion	22.70	ΥZ	11.09	3.63	0
43501		*	Surgical repair of stomach	22.47	N.	10.96	3.61	060	43842	z	V-band gastroplasty	20.90	NA	9.72	1.12	0
43502		4	Surgical repair of stomach	25.56	NA A	12.29	4.14	060	43843	٧	Gastroplasty w/o v-band	21.08	NA	10.29	3.41	0
43510		¥	Surgical opening of stomach	15.01	۷ Z	9.10	2.43	060	43845	A	_	33.12	NA	15.91	5.35	0
43520		¥	Incision of pyloric muscle	11.21	NA AN	5.91	1.89	060	43846	∢	Ť	27.23	NA	13.51	4.37	0
43600		٧	Biopsy of stomach	1.91	NA	0.80	0.15	000	43847	A	•	30.10	NA	14.61	4.87	0
43605		4	Biopsy of stomach	13.64	Y.	7.13	2.17	060	43848	Ą		32.57	NA	15.45	5.23	0
43610		A	Excision of stomach lesion	16.26	AN	8.16	2.59	060	43850	¥	_	27.45	NA NA	12.99	4.45	0
43611		¥	Excision of stomach lesion	20.25	A A	10.16	3.22	060	43855	₩.	_	28.56	NA	12,49	4.63	0
43620		¥	Removal of stomach	33.91	AN	15.12	5.47	060	43860	A	_	27.76	X.	13.09	4.43	0
43621		٧	Removal of stomach	39.40	NA	17.20	6.35	060	43865	¥	_	28.92	Ϋ́	13.54	4.68	0
43622		V	Removal of stomach	39.90	K Z	17.43	6.46	060	43870	<	_	11.36	∢ Z	6.35	8/:	۰ د
43631		K	Removal of stomach, partial	24.38	Y Y	11.72	3.91	060	43880	∀ '		27.05	AN .	12.76	4.27	٠ :
43632		∢	Removal of stomach, partial	35.01	NA.	15.66	5.62	060	43881	υ i	Impl/redo electrd, antrum	0:00	0.00	0.00	0.00	> >
43633		4	Removal of stomach, partial	33.01	YN.	14.85	5.28	060	43882	υ.	Revise/remove electrd antrum	0.00	0.00	00.0	0.00	,
43634		ď	Removal of stomach, partial	36.51	Z.	16.36	5.91	060	43886	∢ ·	Revise gastric port, open	40.4	¢ :	n o	0.74	> <
43635		¥	Removal of stomach, partial	2.06	Y.	0.76	0.33	777	45887	∢ .	Kemove gastric port, open	4.24	e z	3.50	0.09	> <
43640		Κ.	Vagotomy & pylorus repair	19.43	Z ;	9.93	3.10	060	43888	d; (Change gastric port, open	6.34	t 8	20.0	60.0	> >
43641		₹ .	Vagotomy & pylorus repair	19.68	d d	10.11	5.19	060	43999	> ر	Stomach surgery procedure	18 38	3.5	0000	288	. <
43644		∢ .	Lap gastric bypass/roux-en-y	77.67	C :	15.93	1,71	060	44003	€ <	Incident of parell bound	14.19	(× Z	7 13	3.36	• •
43645		∢ (Lap gastr bypass incl smu i	000	000	0.00	000	747Y	44015	< <	Insert needle cath bowel	2.62	S Z	0.95	0.42	, 13
43640) د	I on revised from alred output	000	900	000	000		44020	×	Explore small intestine	16.14	Ϋ́	8.06	2.54	0
43651		ه د	Lap revise remy end and an	10.13	S N	81.9	164	060	44021	< <	Decompress small bowel	16.23	NA	8.1	2.57	0
43031		< 4	Laparoscopy, ragus nerve	12.13	. Z	6 97	96 1	060	44025	. ∢	Incision of large bowel	16.43	X	8.23	2.54	0
43653		: ∢	Lanaroscomy, pastrostomy	838	X	5.75	1.35	060	44050	×	Reduce bowel obstruction	15.44	NA	7.86	2.45	0
	1 CPT	orles and	CPT codes and descriptions only are convirunt 2009 American Medical Association. All Rights	American Mex	dical Associa	rion, All Rig	hts			PT codes	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	cal Associati	on. All Righ	ts.	
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	2 If val	ues are re	If values are reflected for codes not payable by Medicare, please note that these values have been	are, please no	ore that these	values have t	een		7,	f values are	If values are reflected for codes not payable by Medicare, please note that these values have been	are, please note	that these v	alues bave b	GD.	
	Stabin The b	shed as a udget ner	established as a courtesy to the general public and are not used for medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	redicare payn n is not reflec	rent. ted in the R\	Us for CPT		3.5	The budget	istabilistica as a countest to the general phone and are not used for interment parameter. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflect	ed in the RV	Us for CPT	
	codes 5	18940,98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be	reflected in	the files used	for		8:	des 98940,	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	a will only be r	eflected in th	e files used	for	
	Medic	Medicare payment	leut.	onit money					Σ÷	Medicare payment.	dedicare payment. Clobal totals for maloractica DVI is may not sum due to rounding	o roundino				
	CIOD	1 10tals 1	Global lotals for maipractice K v Us may not sum due to rounding.	to rounding.					•	JUNEAU INTER	S 101 mapparine is to smay act own con a	O l'Outroung.				

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I fivalues are reflected for codes not payable by Medicare, please note that these values have been setabilished as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Global display and a state of the part of

Mai- Practice RVUs ^{23,4}	4.37	5.97	4.79	0.51	9.0	0.00	95.5	00.7	7.16	3.80	3,00	2.13	1.39	2.54	2.92	0.18	0.20	0.25	0.27	0.24	0.30	0.31	0.32	0.38	0.45	0.40	0.49	0.50	0.08	0.10	0.22	0.18	0.20	0.28	0.26	0.26	0.33	0.36	0.43	65.0	sints
Facility PE RVUs ^{2:3}	15.39	19.21	17.92	1.50	5.43	0.00	0.7	4 7 4	27.9	11.63	10.23	11.58	6.34	9.24	10.20	1.41	1.54	1.77	1.90	1.72	2.21	2.26	2.54	5,13	2.50	2.68	3.39	3.73	0.70	0.82	1.35	0.94	1.14	4.	1.60	1.67	2.10	.83	2.30	2.14	non. All Ka
Non- Facility PE RVUs ^{2,3}	NA	ΝĀ	Ϋ́	ď ;	₹ 8	0.00	< 2 2 2	₹ ×	< ×	2	N A	NA	NA	NA	NA	NA	NA	Y.	N.	NA	NA	Ν	V.	Z 2	K Z	N A	A'N	NA	NA	NA	V.	4.62	15.9	5.93	6.67	7.72	7.99	7.16	7.75	8.01	ical Associa
Physi- clan Work RVUs ^{2 3}	29.88	36.87	34.37	3.50	28.49	0.00	13.03	17.49	5,51	23.46	19.75	13.15	9.12	17.06	19.47	2.59	2.87	3.49	3.73	3.31	4.40	4.51	4.79	4,40	5.49	5.52	7.12	7.46	1.05	1,27	2.94	1.82	2.12	2.82	3.13	3.82	4.31	3.8	4.83	4.42	петсан Мед
Description	Laparo total proctocolectomy	Lap colectomy w/proctectomy	Laparo total proctocolectomy	Lap, mobil splenic fl add-on	Lap, close enterostomy	Laparoscope proc, intestine	Open bowel to skin	Heostomy/jejunostomy	Position of Heastonia	Devise howel nough	Colostomy	Colostomy with biopsies	Revision of colostomy	Revision of colostomy	Revision of colostomy	Small bowel endoscopy	Small bowel endoscopy/biopsy	Small bowel endoscopy	Small bowel endoscopy/stent	Small bowel endoscopy	Small bowel endoscopy	Small bowel endoscopy/biopsy	Small bowel endoscopy	S bowel endoscope w/stent	Small bowel endoscopy	Small bowel endoscopy	lleoscopy w/stent	Endoscopy of bowel pouch	Endoscopy, bowel pouch/biop	Colonoscopy	Colonoscopy with biopsy	Colonoscopy for foreign body	Colonoscopy for bleeding	Colonoscopy & polypectomy	Colonoscopy, lesion removal	Colonoscopy w/snare	CPT codes and descriptions only are copyright 2009 American Medical Association. All Kights testived.				
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CPT ^{1,3} / HCPCS	44210	44211	44212	44213	44227	44238	44300	44310	44314	44316	44320	44322	44340	44345	44346	44360	44361	44363	44364	44365	44366	44369	44370	44372	44373	44377	44378	44379	44380	44382	44383	44385	44386	44388	44389	44390	44391	44392	44393	44394	
a 7.	060	000	060	060	060	777	060	060	080	000	XXX	XXX	XXX	XXX	XXX	ZZZ	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	ZZZ	060	060	060	060	060	
Mai- Practics RVUs ^{2,3}	4.06	0.15	2,11	2.52	3.24	0.68	3.05	6.80	0.50	34.0	000	0.00	00.0	0.00	0.00	0.34	3.48	4.61	4.31	4.64	4.20	5.11	5.09	4.6	7.07	6.03	5.75	5.91	3.21	2.37	1.67	2.46	2.87	3.64	0.72	3.94	3.41	4.56	4.66	4.78	Lights
Facility PE RVUs ^{2,3}	11.70	0.88	7.26	8.21	9.80	40.	50.6	19.23	11.12	20.1	0.00	0.00	0.00	00'0	0.00	0.83	11.04	15.84	13.94	14.49	13.26	18.21	15.09	16.86	18.52	20.24	18.96	19.01	10.30	7.74	5.88	10.62	11.53	11,41	1.65	12.46	10.93	14.38	14.41	16.68	ation. All F
Non- Facility PE RVUs ^{2,3}	NA	NA	Ϋ́	Y.	Y :	YZ;	ď:	V :	Y :	< ×	000	000	00.00	0.00	0.00	NA	Ϋ́	NA	Ν	NA	Ϋ́	NA	Y.	ď;	K Z	C Z	Ν	NA	Ν	NA	Ν	NA	NA	Ν	NA	ΝΑ	ΝĄ	Ϋ́	NA.	ď.	lical Associ
Physician Clan Work RVUs ^{2,3}	25.53	2.01	13.96	16.44	20.74	4.44	19.93	42.02	60.64	# 1. 00 I.	0.00	000	0.00	0.00	0.00	2.23	22.46	29.75	27.63	29.75	28.45	35.14	33.56	29.99	34.73	37.23	35.49	36.49	20.78	15.19	10.30	17.27	19.20	23.26	4.44	26.29	22.86	29.63	31.79	33.86	American Me
Description	Correct mairotation of bowel	Biopsy of bowel	Excise intestine lesion(s)	Excision of bowel lesion(s)	Removal of small intestine	Removal of small intestine	Removal of small intestine	Enterectomy w/o taper, cong	Enterectomy w/taper, cong	Enterectomy cong, aug-on	Bowel to cower fusion Enterectomy cadaver donor	Enterectomy, live donor	intestine transplnt, cadaver	intestine transplant, live	Remove intestinal allografi	Mobilization of colon	Partial removal of colon	Partial removal of colon	Partial removal of colon	Partial removal of colon	Partial removal of colon	Partial removal of colon	Partial removal of colon	Removal of colon	Removal of colon/ileostomy	Removal of colon/ileostomy	Colectomy w/ileoanal anast	Colectomy w/neo-rectum pouch	Removal of colon	Lap, enterolysis	Lap, jejunostomy	Lap, ileo/jejuno-stomy	Lap, colostomy	Lap, enterectomy	Lap resect s/intestine, addl	Laparo partial colectomy	Lap colectomy part w/ileum	Lap part colectomy w/stoma	L colectomy/coloproctostomy	L colectomy/coloproctostomy	! CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved.
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Mod Status	¥							¥ ·	Α.	< <	ťΩ	* 22	. ~	α.	O	₹	∢	Y	∢	Ą	¥	٧	¥	A	∢ •	₹ 4	: ∢	4	V	4	4	¥	¥	Ą	A	A	∢	¥	¥	A	CPT codes and c Reserved.

² If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

² The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

⁴ Global totals for malpractice RVUs may not sum due to rounding.

² If values are reflected for codes not payable by Medicare, please note that these values bave been established as a courtesy to the general public and are not used for Medicare payment.

³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

⁴ Global totals for malpractice RVUs may not sum due to rounding.

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Global totals for malpractice R VUs may not sum due to rounding.

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/chldo	:	į		Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice		CPT ^{1,3} /		į	Č	Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	ē
HCPCS	Pow	Status		#0A.	**************************************	KNUS	KV08	Gional		10 BOM	Status	nescription	2 40 C	* * C * C	80AL	10 AV	5 `
45381		∢ .	Colonoscopy, submucous inj	9.19	3.6	2.09	100	900	46200		z. :	cemoval of anal results	5.48	8.5	10.4	0.40	_
45382		<	Colonoscopy/control pieceing	0.00	7.70	61.7	17.	000	0170+		٠,	celloval of alial crypt	2.73	7.17	77.7	* * * *	, ,
45383		∢	Lesion removal colonoscopy	5.86	8.20	2.73	0.51	000	46211		Α.	Removal of anal crypts	4.31	8.32	4.94	0.70	۰ ت
45384		∢	Lesion remove colonoscopy	4.69	6.87	2.25	0.41	000	46220		Κ.	temoval of anal tag	1.58	3.49	1.37	0.21	
45385		<	Lesion removal colonoscopy	5.30	7.72	2.56	0.41	000	46221		¥	igation of hemorrhoid(s)	2.31	4.32	2.42	0.30	
45386		¥	Colonoscopy dilate stricture	4.57	11,46	2.20	0.40	000	46230		Ψ.	Removal of anal tags	2.59	4.19	1.75	0.35	_
45387		٧	Colonoscopy w/stent	5.90	NA	2.93	0.47	000	46250		۲ ۲	Hemorrhoidectomy	4.17	7.12	3.58	1970	_
45391		¥	Colonoscopy w/endoscope us	5.09	ΝA	2.48	0.37	000	46255		Α.	Hemorrhoidectomy	4.88	7.54	3.87	0.72	_
45392		<	Colonoscopy w/endoscopic fib	6.54	Ν	3.10	0.50	000	46257		¥	Remove hemorrhoids & fissure	5.68	NA	4.85	0.79	_
45395		∢	Lap, removal of rectum	32.79	Ϋ́N	17.80	4.44	060	46258		A	Remove hemorrhoids & fistula	6.28	ΝΑ	5.23	1.02	0
45397		K	Lap, remove rectum w/pouch	36.29	NA	18.84	4.54	060	46260		Ą	Hemorrhoidectomy	6.65	AN	5.17	0.95	_
45400		4	Laparoscopic proc	19.31	NA	06'6	2.68	060	46261		A	Remove hemorrhoids & fissure	7.63	N.	5.57	1.03	_
45402		V	Lap proctopexy w/sig resect	26.38	NA	12.57	3.61	060	46262		A	Remove hemorrhoids & fistula	7.80	NA	10.9	1.07	_
45499		ပ	Laparoscope proc, rectum	0.00	00.00	0.00	0.00	٨٨٨	46270		Ą	Removal of anal fistula	4.81	7.60	4.82	0.72	0
45500		¥	Repair of rectum	7.64	NA	5.64	06'0	060	46275		A.	Removal of anal fistula	5.31	7.92	4.96	0.72	_
45505		٧	Repair of rectum	8.20	NA A	6.49	1.12	060	46280		H H	Removal of anal fistula	6.28	NA	5.39	0.83	_
45520		٧	Treatment of rectal prolapse	0.55	3.28	0.49	90.0	000	46285		A	Removal of anal fistula	5.31	7.85	4.97	89.0	_
45540		4	Correct rectal prolapse	18.02	Ν	8.91	2.34	060	46288		A F	Repair anal fistula	7.68	NA	6.01	1.00	_
45541		۷	Correct rectal prolapse	14.72	NA	8.78	1.93	060	46320		A	Removal of hemorrhoid clot	1.62	2.90	1.15	0.20	0
45550		4	Repair rectum/remove sigmoid	24.67	NA	12.59	3.34	060	46500		A	injection into hemorrhoid(s)	1.64	4.19	1.57	0.20	0
45560		*	Repair of rectocele	11.42	Z.	6.32	1.33	060	46505		Α	Chemodenervation anal musc	3.13	3.98	2.86	0.41	0
45562		٧	Exploration/repair of rectum	17.82	NA	10.09	2.51	060	46600			Diagnostic anoscopy	0.55	1.61	0.49	90:0	
45563		₹	Exploration/repair of rectum	26.22	N A	14.61	4.25	060	46604		٧	Anoscopy and dilation	1.03	13.88	19.0	0.12	_
45800		V	Repair rect/bladder fistula	20.18	NA	66.6	2.54	060	46606		7	Anoscopy and biopsy	1.20	4.32	0.74	0.15	
45805		ď	Repair fistula w/colostomy	23.19	NA	13.04	3.76	060	46608			Anoscopy, remove for body	1.30	4.42	0.71	0.16	_
45820		V	Repair rectourethral fistula	20.24	NA	9.01	1.47	060	46610		-	Anoscopy, remove lesion	1.28	4.29	0.78	0.17	_
45825		4	Repair fistula w/colostomy	24.01	Ϋ́	13.79	2.61	060	46611		٧	Anoscopy	1.30	2.97	0.77	0.13	٠.
45900		K	Reduction of rectal prolapse	2.96	N.	2.10	0.40	010	46612		۷ ۷	Anoscopy, remove lesions	1.50	5.01	0.87	0.19	Ψ,
45905		∢	Dilation of anal sphincter	2.32	N.	6.	030	010	46614		۷ ۷	Anoscopy, control bleeding	00.1	2.17	99.0	0.11	
45910		٧	Dilation of rectal narrowing	2.82	Y Y	2.07	0.34	010	46615		٠ ۲	Anoscopy	1.50	2.03	0.84	61.0	٠ .
45915		∢ .	Remove rectal obstruction	3.16	4.82	2.45	0.32	010	46700		ζ,	Repair of anal stricture	89.68	ΨZ;	6.78	1.23	
45990		< (Surg dx exam, anorectal	08.1	Z 2	5 6	0.24	000	40/03		* •	Repair of anal stricture	75.7	Z Z	5.74	65.0	٠ ر
45999		. د	Rectum surgery procedure	000	9,6	00.0	0.00	777	40/00		z, ;	Kepr of anal fistula w/glue	2,41	ď.	79.1	0.32	,
07004		∢ •	Flacement of seton	\$6.7 6	3.88	99.7	0.40	010	40/10		* F	Repr per/vag pouch sngi proc	17.01	e s	10.01	50.7	-
46040		₹ <	training of rectal marker	5 7.1	7.70	707	0.10	910	21/04		4 C	Repr per/yag pouch abi proc	20.02	\$ X	# 60 F	C (4)	,
46045		< <	Incision of rectal absents	07.0	0 V	707	0.76	060	61794		4 n	Nep per amper usu Jan narf angnariyaatib fisti	1 2	C V	13.18	184	, (
46050		< ∢	Incision of anal absense	121	3.72	171	0.16	010	46730		٠ <	Construction of absent anus	30.17	(Y	24.76	797	, ,
46060		<	Incision of rectal abscess	6.24	X	5.54	0.87	060	46735		. <	Construction of absent anus	35.66	×	18.01	6	0
46070		<	Incision of anal septum	2.74	N A	2.85	0.15	060	46740		Α.	Construction of absent anus	33.42	NA.	19.27	5.41	ب
46080		Y	Incision of anal sphincter	2.50	3.66	1.49	0.36	010	46742		A	Repair of imperforated anus	39.66	NA	21.26	2.12	0
46083		Y	Incise external hemorrhoid	1.42	2.83	1.23	0.14	010	46744		A	Repair of cloacal anomaly	58.46	ΝA	27.68	6.34	0
	1 CPT c	codes and	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	lical Associa	tion. All Rig	ghts		_	CPT code	s and des	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medi	cal Associat	ion, All Righ	ts	
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Mal- Practice RVIs ^{2,3}			4.90	4.53	0.00	0.70	3.12	000	1.92	2.73	2.35	4.05	0.25	2.54	0.25	2.76	1.27	0.10	0.10	0.13	2.73	3.35	3.95	2.54	1.24	1.72	0.68	0.69	1.66	0.99	1.09	0.55	0.00	2.5	0.64	0.23	0.87	Rights ve been	sed for
Facility PE RVIIs ^{2,3}	10.71	11.26	14.29	13.29	0.00	06.1	12.70	000	6.72	8.56	7.52	13.11	1.02	8,53	1.20	66.8	6.19	0.44	0.47	0.52	9.85	12.07	13.65	8.37	5.48	7.16	3.04	3.29	5.63	3.57	3.73	1,27	00:0	7.76	97.7	61.1	3.71	stion. All values bay	the files u
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Physi- clan Work	21.86	22.10	30.25	27.96	0.00	4.30	10.74	000	12.44	17.55	15.98	26.46	3.37	16.41	3.99	18.42	5.09	1.35	1.26	1.73	20.00	26.00	30.00	15.70	8.93	12.41	5.09	5.96	10.13	6.27	6.77	3.50	00:0	14.01	14:01	2.22	5.87	American Med care, please not not used for Me	demonstration on will only be to rounding.
Danvelotion	Description First pancreas ovst and bowel	Pancreatorrhaphy	Duodenal exclusion	Fuse pancreas and bowel	Prep donor pancreas	Prep donor pancreas/venous	Personal allogram panereas	Neuroval, auograni paucicas Pancreae surgery procedure	Exploration of abdomen	Reopening of abdomen	Exploration behind abdomen	Drain abdominal abscess	Drain abdominal abscess	Drain, open, abdom abscess	Drain, percut, abdom abscess	Drain, open, retrop abscess	Drain, percut, retroper absc	Puncture peritoneal cavity	Removal of abdominal fluid	Biopsy, abdominal mass	Exc abd tum 5 cm or less	Exc abd turn over 5 cm	Excise seems sains tumor	Multiple surgery, abdomen	Excision of umbilicus	Removal of omentum	Diag laparo separate proc	Laparoscopy, propsy	Laparo drain lymphocele	Lap insertion perm ip cath	Lap revision perm ip cath	Lap w/omentopexy add-on	Laparo proc, abdm/per/oment	An injection and accounting	Trans abdem and for abounce	Instit abdom drain, temp	Insert abdom drain, perm	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Preserve in the payable by Medicare, please note that these values have been Fif saltee are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.	I ne budget reductanty reduction from the chiropractic demonstration is not reducted in the rives for codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payman. We will see that the files used for Ciphal totals for malmactice RVIs may not sum due to roundine.
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Mal- Practice	3.42			2.65	4.63	4.15	44.6	2.47	3.54	3.42	3.90	6.11	8.42	6.80	80.6	4.19		3.55	00:00	5.15	6.41	3.07	2.26	7.85	2.96	4.20	4.41	3.28	8.50	7.85	8.49	7.89	4.74	5.0	26.7	0.70	2.90	ghts	d for
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/ Mal- Practice			1.56		1.7		3.63				0.4	0.4	4.0	0.5	0.7	9.0	0.7	8.0	3. 6		0.7	0.4	9.0	1.2	5.5	-		4.	1.51	9 0	0.09	0.08	1.2	1.7	2.28	1.45	0.63	85	3.2	Rights	ve been	RVUs for	
Facility	RVUs	7.18	9.13	11.50	9.27	10.04	14.00	9.95	0.00	2.16	2.23	2.45	2.49	2.80	4.34	3.41	3.67	3.89	06.4	4.16	4.88	2.60	3.51	7.32	7.40	7.13	7.06	8.17	8.82	0.34	0.83	0.64	7.64	69.6	8.70	8.55	4.71	2.32	10.33	ation. All	values ha nent.	cted in the	
Non- Facility PE	RVUs	NA	NA A	Y.	NA:	Y X	ζ 4 Ζ 2	. Y	0.00	3.64	3.87	4.05	4.15	4,65	NA.	Z V	Z.	V Z	K 2	(13.18	62.27	92.65	Y X	ζ 4	Y Y	N A	Ϋ́	AN of t	2.30	NA	1,26	Z V	Ϋ́	N.	Y Z	V X	ζ.	ž	cal Associ	that these dicare pays	is not refle effected in	
Physi- cian Work	RVUs	16.76	21.18	27.18	23.27	24.93	26.09	25.26	0.00	5.59	5.98	6.52	6.61	7.58	10.90	9.53	10.33	90 5	13.90	11.84	9.64	6.77	80.6	17.04	17.13	16.30	16.08	18.67	20.87	1.51	1.18	1.16	16.54	20.49	17.80	20.05	8.17	17:00	19,92	merican Medi	are, please note of used for Me	demonstration	
	Description	Laparo ablate renal cyst	Laparo ablate renal mass	Laparo partial nephrectomy	Laparoscopy, pyeloplasty	Laparo radical nephrectomy	Laparoscopic nephrectomy I aparo removal donor kidney	Laparo remove w/ureter	Laparoscope proc, renal	Kidney endoscopy	Kidney endoscopy	Kidney endoscopy & biopsy	Kidney endoscopy & treatment	Kidney endoscopy & treatment	Renal scope w/tumor resect	Kidney endoscopy	Kidney endoscopy	Kidney endoscopy & biopsy	Kidney endoscopy	Kidney endoscopy & treatment	Fragmenting of kidney stone	Perc rf ablate renal tumor	Perc cryo ablate renal tum	Exploration of ureter	insert ureteral support	Removal of ureter stone	Removal of ureter stone	Removal of ureter	Removal of ureter	Advanted to the test Andy	Change of ureter tube/stept	Injection for ureter x-ray	Revision of ureter	Release of ureter	Release of ureter	Release/revise ureter	Revise ureter	Kevise meier	Fusion of ureter & kidney	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights teserved.	² If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT order 8894th 98941 and 98942. The remained reduction will only be reflected in the files used for	Aedicare payment.
	Status	¥	¥	٧	٧	٧.	∢ ∢	ζ Κ	ပ	¥	¥	¥	Α.	¥	∀	¥	Ą	۷,	< <	ζ∢	< ∢	٧	Ą	∢ •	< 4	: ∢	Α	¥	Α.	< ∢	< <	¥	A	¥	Ą	A	∢•	<	٧	odes and o	es are refl ted as a c	dget neut	Medicare payment.
	Mod																																							CPT coc Reserved.	² If value establish	The bu	Medicar
CPT's	HCPCS	50541	50542	50543	50544	50545	50546	50548	50549	50551	50553	50555	50557	50561	20262	50570	50572	50574	5/505	50580	50590	50592	50593	20600	50605	50620	\$0630	80650	20060	50084	50688	20690	50700	50715	50722	50725	50727	97/00	50740				
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	RVUs224	0.00	1.64	1.79	1.83	1.82		08:1	1.37	1.16	2.91	0.00	0.00	0.59	0.50	0.34	2.24	6.22	7.40	4.80	0.40	0.36	0.33	0.24	0.13	0.14	0.14	0.24	0.30	0.00		0.11	1.56	1.86	3,41		3.92	04:1	1.52	on. All Rights	alues have been	ed in the RVUs for CPT	
Mal- Practice	RVUs ²³ RVUs ^{23,4}	0.00 0.00	8.28 1.64	9.32 1.79	9.63 1.83	9,90 1.82	1.96	9.64	7.66 1.37	7.23 1.16	13.48 2.91	0.00 0.00	0.00 0.00	1.45 0.59	1.26 0.50	1.14 0.34	9.48 2.24	23.23 6.22	24.93 7.40	10.55 4.80	1.71 0.40	1.56 0.36	0.33	1.30 0.24	0.39 0.15	0.59 0.14	0.69 0.14	1,29 0.24	1.52 0.30	0.51 0.00	0.15	0.47 0.11	8.93 1.56	10.59 1.86	10.30 3.41	8,12 1.36	12.12 3.92	11.84	1.52	al Association. All Rights	that these values have been icare payment.	and reflected in the RVUs for CPT	
Facility Mal- PE Practice	RVUs ²³ RVUs ²³ RVUs ^{23,4}	0.00 0.00 0.00	NA 8.28 1.64	NA 9.32 1.79	NA 9.63 1.83	NA 9.90 1.82	11.33 1.96	NA 9.64 [.6]	NA 7.66 1.37	NA 7.23 1.16	NA 13.48 2.91	0.00 0.00	0.00 0.00 0.00	NA 1.45 0.59	NA 1.26 0.50	NA 1.14 0.34	NA 9.48 2.24	NA 23.23 6.22	NA 24.93 7.40	10.55 4.80	18.91 1.71 0.40	14,19 1.56 0.36	19.36 1.62 0.33	12.29 1.30 0.24	0.39 0.15	NA 0.59 0.14	1.27 0.69 0.14	NA 1.29 0.24	NA 1.52 0.30	0.51 0.00	NA 0.90 0.15	8.22 0.47 0.11	NA 8.93 1.56	NA 10.59 1.86	NA 10.30 3.41	8,12 1.36	NA 12.12 3.92	NA 11.84 1.40	1.52	American Medical Association. All Rights	are, please note that these values have been or used for Medicare payment.	demonstration is not reflected in the RVUs for CPT	Hall only or restrance in the trees made to
Non- Facility Facility Mal- PE PE Practice	RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4}	1 cmon 0.00 0.00 0.00 0.00	18.53 NA 8.28 1.64	NA 9.32 1.79	NA 9.63 1.83	23.90 NA 9.90 1.82	ter 26.74 NA 11.33 1.96	NA 9.64 [6]	16.94 NA 7.66 1.37	16,00 NA 7.23 1.16	10r 22.28 NA 13.48 2.91	0.00 0.00 0.00	0.00 0.00 0.00	4.00 NA 1.45 0.59	3.50 NA 1.26 0.50	1 3.34 NA 1.14 0.34	13.86 NA 9.48 2.24	40.45 NA 23.23 6.22	45.68 NA 24.93 7.40	NA 10.11 4.80	th 5.50 18.91 1.71 0.40	t 5.00 14.19 1.56 0.36	4.44 19.36 1.62 0.33	h 3.30 12.29 1.30 0.24	9.28 0.39 0.15	1.96 NA 0.59 0.14	1.96 1.27 0.69 0.14	3.37 NA 1.29 0.24	4.15 NA 1.52 0.30	7 0.76 1.70 0.51 0.00	NA 0.90 0.15	1.46 8.22 0.47 0.11	reter 21.12 NA 8.93 1.56	NA 10.59 1.86	NA 10.30 3.41	18.73 NA 8.12 1.36	24.21 NA 12.12 3.92	20.13 INA 11.84 1.40	NA 8.85 1.52		ected for codes not payable by Medicare, please note that these values have been urriesy to the ceneral public and are not used for Medicare payment.		t the control of the
Non- Facility Facility Mal- PE PE Practice	RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4}	1 cmon 0.00 0.00 0.00 0.00	18.53 NA 8.28 1.64	21.73 NA 9.32 1.79	Removal kidney open, radical 23.68 NA 9.63 1.83	Removal of kidney & ureter 23.90 NA 9.90 1.82	Removal of kidney & ureter 26.74 NA 11.33 1.96	Croshlate renal mass onen 22.06 NA 9.64 [6]	16.94 NA 7.66 1.37	Removal of kidney lesion 16.00 NA 7.23 1.16	Remove kidney, living donor 22.28 NA 13.48 2.91	0.00 0.00 0.00	Prep donor renal graft 0.00 0.00 0.00 0.00 0.00	Prep renal graft/venous 4.00 NA 1.45 0.59	3.50 NA 1.26 0.50	Prep renal graff/ureteral 3.34 NA 1.14 0.34	Removal of kidney 13.86 NA 9.48 2.24	Transplantation of kidney 40.45 NA 23.23 6.22	45.68 NA 24.93 7.40	Kemove transplanted Kidney 15.06 NA 11.01 2.00	5.50 18.91 1.71 0.40	Remove ureter stent, percut 5.00 14.19 1.56 0.36	Change stent via transureth 4,44 19.36 1.62 0.33	3.30 12.29 1.30 0.24	Change ext/int ureter stent 2.00 9.28 0.59 0.15	1.96 NA 0.59 0.14	Instill rx agent into rnal tub 1.96 1.27 0.69 0.14	Insert kidney drain 3.37 NA 1,29 0.24	Insert ureteral tube 4.15 NA 1.52 0.30	Injection for kidney x-ray	2.04 NA 0.90 0.15	Change kidney tube 1.46 8.22 0.47 0.11	Revision of kidney/ureter 21.12 NA 8.93 1.56	25.68 NA 10.59 1.86	21.07 NA 10.30 3.41	18.73 NA 8.12 1.36	Repair renal-abdomen fistula 24.21 NA 12.12 3.92	Repair renal-abdomen fistula 20.13 IVA 11.54 1.40	20.95 NA 8.85 1.52	ies and descriptions only are copyright 2009 American Med	es are reflected for codes not payable by Medicare, please note that these values have been ed as a courtesy to the centeral public and are not used for Medicare payment.		27-40, 2027-1, and 2077-2. The topuncal tendential material of tendence in the face medical tendence.
Non- Facility Facility Mal- PE PE Practice	Description RVUs ^{2,3} RVUs ^{2,3,4}	1 cmon 0.00 0.00 0.00 0.00	Remove kidney, open 18.53 NA 8.28 1.64	Removal kidney open, complex 21.73 NA 9.32 1.79	Removal kidney open, radical 23.68 NA 9.63 1.83	Removal of kidney & ureter 23.90 NA 9.90 1.82	Removal of kidney & ureter 26.74 NA 11.33 1.96	Croshlate renal mass onen 22.06 NA 9.64 [6]	Removal of kidney lesion 16.94 NA 7.66 1.37	Removal of kidney lesion 16.00 NA 7.23 1.16	Remove kidney, living donor 22.28 NA 13.48 2.91	Prep cadaver renal allograft 0.00 0.00 0.00 0.00	Prep donor renal graft 0.00 0.00 0.00 0.00 0.00	Prep renal graft/venous 4.00 NA 1.45 0.59	Prep renal graft/arterial 3.50 NA 1.26 0.50	Prep renal graff/ureteral 3.34 NA 1.14 0.34	Removal of kidney 13.86 NA 9.48 2.24	Transplantation of kidney 40.45 NA 23.23 6.22	Transplantation of kidney 45.68 NA 24.93 7.40	Kemove transplanted Kidney 15.06 NA 11.01 2.00	Change irrefer stent, negat 5.50 18.91 1.71 0.40	Remove ureter stent, percut 5.00 14.19 1.56 0.36	Change stent via transureth 4,44 19.36 1.62 0.33	Remove stent via transureth 3.30 12.29 1.30 0.24	Change ext/int ureter stent 2.00 9.28 0.59 0.15	Drainage of kidney Jesion 1.96 NA 0.59 0.14	Instill rx agent into rnal tub 1.96 1.27 0.69 0.14	fusert kidney drain 3.37 NA 1,29 0.24	Insert ureteral tube 4.15 NA 1.52 0.30	Injection for kidney x-ray	Create passage to kidney 3.37 NA 1.32 0.23 Measure kidney pressure 7.09 NA 0.90 0.15	Change kidney tube 1.46 8.22 0.47 0.11	Revision of kidney/ureter 21.12 NA 8.93 1.56	Revision of kidney/ureter 25.68 NA 10.59 1.86	Repair of kidney wound 21.07 NA 10.30 3.41	Close kidney-skin fistula 18.73 NA 8.12 1.36	Repair renal-abdomen fistula 24.21 NA 12.12 3.92	Repair renal-abdomen fistula 20.13 IVA 11.54 1.40	Revision of horsesboe kidney 20,95 NA 8.85 1.52	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved.	are reflected for codes not payable by Medicare, please no das a courtesy to the general public and are not used for M		COUNTY STAY OF COUNTY AND ASSAULT THE COUNTY STAY OF COUNTY STAY O

	e const	200	900	9	000	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	000	000	000	00	000	000	000	010	010	000	900	000	3 8	3	3 8	8	8 8	900	8	8 8	000							
Mal- Practice	80A2	0.48	90.0	0.08	0.20	0.79	0.73	1.16	1.17	00'1	1.58	1.88	1.78	2.07	2.46	2.55	2.86	2.71	3.04	3.22	3.33	90.0	0.05	80'0	90'0	0.0	9.0	0.1	80.0	0.1	0.27	0.11	0.11	0.00	0.0	0.00	0.00	0.04	0.00	200	0.08	0.00		2	sen	Tra Cont	OS TOT C.P.1		
Facility	KVU8	3.83	0.25	0.36	9	5.45	5.18	96.9	6.56	6.37	7.77	9.84	10.08	11.16	13.53	14.18	15.58	14.22	16.02	17.33	17.07	0.28	0.36	0.60	0.30	0.22	0.29	0.67	89.0	0.94	1.49	0.61	3.39	2.87	0.52	5.03	69.0	6.0	5.70	100	1 00 1	0.62	to: All Diet	ion. An Aug	alues have by	ent.	ed in the K v		
Non- Facility PE	KVC.	Z ,	0.80	2.13	3.01	NA	Ϋ́	NA	٧X	ΝA	NA	ΝΑ	NA	ΥX	Y.	ΥN	NA A	Y Y	ΝΑ	ΝΑ	۲ ۲	3.63	₹ Z	1.62	1.20	0.86	1.25	1.80	1.59	2.13	3.57	1.28	3.39	2.87	0.52	5.03	60.0	0.73	6.73	100	1 00	0.62	ing A property	ICAI ASSOCIAL	e that these v	dicare paym	is not retiect reflected in ti		
Physi- cian Work	RVUs	19.9	0.78	1.02	2.70	10.92	10.08	15.29	13.58	13.77	17.10	23.03	23.50	27.31	34.00	35.14	39.41	36.15	41.12	44.01	42.61	0.88	0.64	1.05	88.0	0.50	0.50	1.47	1.03	1.50	3.73	1.50	1.51	0.00	5	1.7	3 -	17.1	.00	9.0	1970	000	monitors Mod	mencan mea	re, please not	ot used for Me	temonstration will only be	Ì	o rounding.
	Description	Drainage of bladder abscess	Drain bladder by needle	Drain bladder by trocar/cath	Drain bl w/cath insertion	Removal of bladder cyst	Removal of bladder lesion	Removal of bladder lesion	Removal of bladder lesion	Repair of ureter lesion	Partial removal of bladder	Partial removal of bladder	Revise bladder & ureter(s)	Removal of bladder	Removal of bladder & nodes	Remove bladder/revise tract	Removal of bladder & nodes	Remove bladder/revise tract	Remove bladder/revise tract	Remove bladder/create pouch	Removal of pelvic structures	Injection for bladder x-ray	Preparation for bladder xray	Injection for bladder x-ray	Irrigation of bladder	Insert bladder catheter	Insert temp bladder cath	Insert bladder cath, complex	Change of bladder tube	Change of bladder tube	Endoscopic injection/implant	Treatment of bladder lesion	Simple cystometrogram	Simple cystometrogram	Simple cystometrogram	Complex cystometrogram	Complex cystomenogram	Complex cystomerogram	United flow measurement	This is a second of the second	Unite now measurement Flectrounoflowmetry first	Flectro-inoflowmetry first	denominations and the growing speciments 2000 A	CFT codes and descriptions only are copyright 2009. American intential Association, thu fugure	Yearness are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	The budget beutrainty reduction from the chrropractic demonstration is not reflected in the K VUS for CFT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	it.	Global totals for malpractice RVUs may not sum due to rounding
	Status	K	Ą	٧	٧	٧	Y	٧	٧	٧	٧	٧	۷	٧	Y	Ą	٧	٧	٧	≺	٧	۷	٧	٧	۷	¥	٧	4	٧	٧	٧	٧	٧	۷.	٧.	< <	ζ.	< <	¢ <	ς -	€ <	; ∢	1	odes and o	s are refl	ed as a co	dget neut 940, 989	Medicare payment	totals for
	Pog M																																	22	56	Ú,	2 6	07	Ţ	2 5	07	J.	100	Pecerued Pecerued	2 If value	establish	Codes 98	Medican	*Globa!
CPT1-3y	HCPCS	51080	51100	51101	51102	51500	51520	51525	51530	51535	51550	51555	51565	51570	51575	51580	51585	51590	51595	51596	51597	21600	51605	51610	51700	51701	51702	51703	51705	51710	51715	51720	\$1725	51725	\$1725	51726	2112	51726	21736	00110	51750	\$1741	-						
Mat Practice	•	1.53 090	060 261	1.53 090																3.25 090								0.49 000								0.00 XXX			0.53		0.58 0.90				,	į į	for CPT		
_	_																																											II Kignts	ave been		he R VUS		
Facility	_				8.75	8.3	10.5	9.3	7.5	12.10	9.60	10.2	12.50	13.3	9.64	10.0	7.5	7.1	7.1	8.55	7.16	7.4	10.38	9.5	0.0	2.2	2.6	2.83	2.5	2.3	2.6	2.5	3.2	3.25	2.53	0.00	Ç.,	4.02	46.3	5.	5.00	5.03	· ·	ciation. A	se values	yment.	lected in I		
Non- Facility PE	RVU ₆ ^{2,3}	NA	Y Z	NA	NA	NA	NA	X	A.	NA	Y.	NA	NA	NA	NA V	N	NA	ΥN	NA	Ν	Ν	NA	NA	NA	0.00	3.81	3.98	4.18	4.25	3.87	NA	ΝA	NA	NA.	NA	0.00	ZZ;	K 4	K .	ď,	K 2	4 2	Ç	ical Asso	te that the	edicare pa	is not ref	Taracara.	
Physi- cian Work	RVUs ^{2,3}	21.07	19.92	21.07	19.80	19.51	20.52	22.08	16.23	22.38	22.06	23.89	30,48	33.57	22.19	22.21	16.93	14.89	15.66	20.04	15.78	17.87	25.63	23.69	0.00	5.83	6.23	6.74	87.9	6.04	7.13	88.9	9.16	9.03	6.84	0.00	0.7	7.68	4. t	20.7	787	2.62	7.07	Атепсап Мес	are, please no	ot used for M	demonstration	a will out y	to rounding.
	d Status Description	 A Fusion of ureter & kidney 	A Fusion of ureters	A Splicing of ureters		A Reimplant ureter in bladder				-		_	_	A Revise urine flow		A Appendico-vesicostomy		A Repair of ureter	 A Closure ureter/skin fistula 	A Closure ureter/bowel fistula		A Laparoscopy ureterolithotomy	,	A Laparo new ureter/bladder		A Endoscopy of ureter	A Endoscopy of ureter			A Ureter endoscopy & treatment	A Ureter endoscopy	 A Ureter endoscopy & catheter 	 A Ureter endoscopy & biopsy 	A Ureter endoscopy & treatment	 A Ureter endoscopy & treatment 	I Rsk fx ref w/n 24 brs x-ray	A incise & treat bladder					A Demonstration and the	A remove meter carcuius	CPT codes and descriptions only are copyright 2009 American Medical Association. All Kights	keserven. ? If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 08042. The required refuseion will only be reflected in the files used for	Godes 96940, 76541, and 76742. The required reduced Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding.
	Mod																																										-	S C	reser 2 If vs	estab	The	Medi	4 Glo
CPT ¹³ 7	HCPCS	50750	50760	50770	50780	50782	50783	50785	50800	50810	50815	50820	50825	50830	50840	50845	50860	20900	50920	50930	50940	50945	50947	50948	50949	15605	50953	50955	50957	50961	50970	50972	50974	50976	50980	5100F	21020	51030	51040	51045	51050	00010	2000						

Percent processed processed Percent Percen	**************************************	Description	Work	PE DVIIe ^{2,3}	PE DVII.	Practice PVIIe 2 3.4	jevolo	CPT ^{1.3} /	ar No.	Description	Work RVIIs ^{2,3}	PE RVUs ^{2,3}	PE RVIIs ^{7,3}	Practice RVUs 2.3.4	Global
11 0.00 2.224	<<<<<<<	Electro-uroflowmetry, first	1.1	0.38	0.38	80.0	000		¥	Cystoscopy w/biopsy(s)	2.59	6.37	Ξ	61.0	000
0.00 \$2224 A Cystoscopy and treatment \$14 11.4 1.29 0.34 11.1 0.00 \$2224 A Cystoscopy and treatment \$44 NA 1.81 0.34 11.1 0.00 \$2229 A Cystoscopy and treatment \$44 NA 1.83 0.31 0.00 \$2226 A Cystoscopy and treatment \$24 NA 1.83 0.31 0.00 \$2226 A Cystoscopy and treatment \$24 NA 1.83 0.32 0.00 \$2226 A Cystoscopy and treatment \$24 NA 1.83 0.34 0.00 \$2227 A Cystoscopy and treatment \$24 NA 1.84 0.34 0.00 \$2227 A Cystoscopy and treatment \$24 NA 1.83 0.34 0.00 \$2228 A Cystoscopy and treatment \$24 NA \$28 0.40 0.10 \$2222 A Cystoscopy and treatme	44444	Urethra pressure profile	1.61	4.27	4.27	0.11	000	52214	Ą	Cystoscopy and treatment	3.70	12.01	1.47	0.27	000
11 10 10 10 11 12 12 13 14 15 15 15 15 15 15 15	,,,,,	Urethra pressure profile	0.00	3.70	3.70	0.00	000	52224	*	Cystoscopy and treatment	3.14	14.11	1.29	0.23	00
11	4 4 4 .	Urethra pressure profile	19.1	0.57	0.57	0.11	000	52234	٧	Cystoscopy and treatment	4.62	Ϋ́	1.83	0.34	000
11	<i>.</i>	Anal/urinary muscle study	1.53	3.35	3.35	0.11	900	52235	¥	Cystoscopy and treatment	5.44	۷ Z	2.13	0.40	9
11 0.00 22255	٠.	AnaVurinary muscle study	0.00	2.83	2.83	0.00	000	52240	Ą	Cystoscopy and treatment	9.71	V.	3.53	0.71	8
10		Anal/urinary muscle study	1.53	0.53	0.53	0.11	000	52250	٧	Cystoscopy and radiotracer	4.49	¥.	88.	0.32	000
1,10, 0,000 52255 A Cystoscopy and treatment 2,94 6,107 1,33 0,24 1,00 0,000 52277 A Cystoscopy and treatment 3,96 5,40 1,40 0,24 1,00 0,000 52277 A Cystoscopy and treatment 4,90 NA 2,68 0,43 1,00 0,000 52278 A Cystoscopy and treatment 6,10 NA 2,68 0,43 1,00 0,000 52228 A Cystoscopy and treatment 6,10 NA 2,68 0,43 1,00 0,000 52228 A Cystoscopy and treatment 5,10 1,27 1,52 1,00 0,000 52228 A Cystoscopy and treatment 5,10 1,43 0,24 1,00 0,000 52228 A Cystoscopy and treatment 5,10 1,43 0,24 1,00 0,000 52228 A Cystoscopy and treatment 5,10 1,43 0,24 1,00 0,000 52228 A Cystoscopy and treatment 5,10 1,42 1,52 1,00 0,000 52229 A Cystoscopy and treatment 5,10 NA 2,18 0,39 1,00 0,000 52230 A Cystoscopy and treatment 5,20 NA 2,18 0,39 1,00 0,000 5,2230 A Cystoscopy and treatment 5,20 NA 2,18 0,39 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 1,79 0,34 1,00 0,000 5,2231 A Cystoscopy and treatment 5,20 NA 1,79 0,34 1,00 0,000 5,2232 A Cystoscopy and treatment 5,20 NA 1,79 0,34 1,00 0,000 5,2232 A Cystoscopy and treatment 5,20 NA 1,79 0,34 1,00 0,000 5,2234 A Cystoscopy and treatment 5,20 NA 1,79 0,34 1,00 0,000 5,2234 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 5,2234 A Cystoscopy and treatment 5,20 NA 2,18 0,49 1,00 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000	,	Anal/urinary muscle study	1.53	3.83	3.83	0.1	000	52260	∢ .	Cystoscopy and treatment	3.91	Y.	1.60	0.28	900
1,000 1,00	_	Anal/urinary muscle study	0.00	3.30	3.30	00'0	000	52265	¥	Cystoscopy and treatment	2.94	6.07	1.33	0.21	000
0.00 \$2273 A Cystoscopy and treatment 469 Λ.16 184 0.34 1.01 0.00 \$2277 A Cystoscopy and treatment 4.69 N.A 1.66 0.35 1.10 0.00 \$2237 A Cystoscopy and treatment 5.30 4.08 1.24 0.34 0.00 \$2238 A Cystoscopy and treatment 5.30 N.A 2.16 0.37 0.00 \$2222 \$2230 A Cystoscopy and treatment 5.30 N.A 2.18 0.40 0.00 \$2222 \$2230 A Cystoscopy and treatment 5.30 N.A 2.18 0.40 0.00 \$2222 \$2300 A Cystoscopy and treatment 5.30 N.A 2.18 0.40 0.00 \$2221 A Cystoscopy and treatment 5.30 N.A 2.18 0.40 0.00 \$2221 A Cystoscopy and treatment 5.30 N.A 2.18 0.40 0	_	Anal/urinary muscle study	1.53	0.53	0.53	0.11	000	52270	¥	Cystoscopy & revise urethra	3.36	5.40	1.40	0.24	8
000 53277 A Cystoscopy and treatment 616 NA 187 0.56 101 000 53277 A Cystoscopy and treatment 616 NA 268 0.43 0.43 0.14 0.20 101 000 5228 A Cystoscopy and treatment 5.80 NA 2.66 0.28 100 222 5228 A Cystoscopy and treatment 4.80 1.24 0.20 100 222 5228 A Cystoscopy and treatment 4.80 NA 1.81 0.34 100 222 52290 A Cystoscopy and treatment 5.80 NA 2.15 0.40 43 050 52310 A Cystoscopy and treatment 5.81 NA 2.15 0.40 43 060 52310 A Cystoscopy and treatment 5.81 NA 2.15 0.40 43 060 52310 A Cystoscopy and treatment 5.81 NA 2.15 0.40 43 060 52310 A Cystoscopy and t	_	Urinary reflex study	1,10	4.09	4.09	80'0	000	52275	×	Cystoscopy & revise urethra	4.69	7.16	1.84	0.34	9
10 10 10 12 12 12 13 14 15 15 15 15 15 15 15	_	Urinary reflex study	0.00	3.71	3.71	0.00	000	52276	A	Cystoscopy and treatment	4.99	Y Y	1.97	0.36	900
1,000 1,00	_	Urinary reflex study	1.10	0.38	0.38	80:0	000	52277	٧	Cystoscopy and treatment	9.16	Y.	2.68	0,43	000
100 000 52283 A Cystoscopy and treatment 3.73 3.12 1.54 0.47 100 2222 52283 A Cystoscopy and treatment 3.69 3.42 1.52 0.26 100 2222 52200 A Cystoscopy and treatment 5.30 NA 2.18 0.03 100 2222 52200 A Cystoscopy and treatment 5.30 NA 2.18 0.04 4.4 090 52310 A Cystoscopy and treatment 5.30 NA 2.18 0.40 4.8 090 52310 A Cystoscopy and treatment 5.30 NA 2.00 0.38 2.9 090 52317 A Cystoscopy and treatment 5.31 NA 2.18 0.40 2.9 090 52317 A Cystoscopy and treatment 5.31 NA 2.28 0.40 2.9 090 52317 A Cystoscopy and treatment 5.31 NA 2.32 0.40 2.9 090 52318 A Cystoscopy and treatm	_	Urine voiding pressure study	1.53	5.35	5.35	0.11	000	52281	¥	Cystoscopy and treatment	2.80	4.08	1.24	0.20	900
11.0 0000 52283 A Cystoscopy and treatment 3.17 3.17 1.56 0.28 10.0 2222 52290 A Cystoscopy and treatment 3.60 NA 1.83 0.33 10.0 2222 52200 A Cystoscopy and treatment 5.30 NA 2.18 0.40 10.0 2223 A Cystoscopy and treatment 5.30 NA 2.18 0.40 12.9 0900 52316 A Cystoscopy and treatment 5.20 5.15 2.00 0.39 12.9 0900 52317 A Cystoscopy and treatment 5.20 5.15 2.00 0.39 18.9 090 52317 A Cystoscopy and treatment 5.20 5.15 5.00 0.34 18.9 090 52317 A Cystoscopy and treatment 5.20 NA 1.10 0.31 18.0 090 52327 A Cystoscopy and treatment 5.20 NA 1.10 <td>_</td> <td>Urine voiding pressure study</td> <td>0.00</td> <td>4.83</td> <td>4.83</td> <td>0.00</td> <td>000</td> <td>52282</td> <td>K</td> <td>Cystoscopy, implant stent</td> <td>6:39</td> <td>Ϋ́</td> <td>2.46</td> <td>0.47</td> <td>900</td>	_	Urine voiding pressure study	0.00	4.83	4.83	0.00	000	52282	K	Cystoscopy, implant stent	6:39	Ϋ́	2.46	0.47	900
0.06 ZZZZ S2258 A Cystoscopy and treatment 3.60 3.42 1.52 0.26 0.06 XZZ 52200 A Cystoscopy and treatment 5.30 NA 2.15 0.39 4.3 090 52300 A Cystoscopy and treatment 5.30 NA 2.15 0.39 4.4 0990 52316 A Cystoscopy and treatment 5.30 NA 2.18 0.40 2.9 090 52316 A Cystoscopy and treatment 5.81 3.12 1.16 0.21 2.9 090 52316 A Cystoscopy and treatment 5.81 NA 2.18 0.49 2.9 090 52318 A Cystoscopy and treatment 5.81 NA 2.38 0.49 3.0 090 52322 A Cystoscopy, and treatment 4.80 NA 2.28 0.49 4.3 090 52322 A Cystoscopy, and treatment 4.81 NA <	_	Urine voiding pressure study	1.53	0.52	0.52	0.10	000	52283	4	Cystoscopy and treatment	3.73	3.27	1.56	0.28	90
222 52390 A Cystoscopy and treatment 4.38 b. NA 183 0.33 100 XXX 52300 A Cystoscopy and treatment 5.30 b. NA 2.15 b. 0.39 4.4 090 52305 A Cystoscopy and treatment 5.50 b. NA 2.18 b. 0.49 8.6 090 52316 A Cystoscopy and treatment 5.50 b. NA 2.18 b. 0.49 2.8 090 52318 A Cystoscopy and treatment 5.20 b. 5.15 b. 1.06 b. 0.39 2.8 090 52318 A Cystoscopy and treatment 5.20 b. 5.15 b. 0.49 3.6 090 52318 A Cystoscopy and treatment 5.20 b. 5.15 b. 0.49 3.6 090 52318 A Remove bladder stone 6.71 b. 1.09 b. 0.34 3.6 090 52320 A Cystoscopy and treatment 5.20 b. NA 1.71 b. 0.34 3.6 090 52324 A Cystoscopy and treatment 5.20 b.	4'	Intraabdominal pressure test	0.80	1.96	96.1	90:0	ZZZ	52285	¥	Cystoscopy and treatment	3.60	3.42	1.52	0.26	000
(1) XXX 5230 A Cystoscopy and treatment 5.30 NA 2.18 0.39 43 900 XXXX 52301 A Cystoscopy and treatment 5.30 NA 2.18 0.40 43 900 52317 A Cystoscopy and treatment 5.30 NA 2.02 0.39 29 900 52317 A Cystoscopy and treatment 5.31 3.12 1.16 0.21 18 900 52317 A Cystoscopy and treatment 5.31 1.30 2.43 0.49 18 900 52317 A Cystoscopy since ramoval 6.13 NA 2.43 0.49 18 900 52320 A Cystoscopy, since ramoval 6.15 NA 1.79 0.49 18 900 52320 A Cystoscopy, since ramoval 6.15 NA 1.79 0.49 19 900 52330 A Cystoscopy, since ramoval 6.15 NA 1.71 0.34 10 900 52334 A Cystoscopy	₹	Intraabdominal pressure test	00.0	1.69	1.69	0.00	222	52290	4	Cystoscopy and treatment	4.58	Y Y	1.83	0.33	90
0.00 XXX 52301 A Cystoscopy and treatment 5.50 NA 2.18 0.40 4.3 090 52316 A Cystoscopy and treatment 5.50 NA 2.18 0.40 0.8 090 52316 A Cystoscopy and treatment 2.81 3.15 2.00 0.38 1.9 0.00 52317 A Remove bladder stone 6.71 1.10 0.243 0.49 1.8 0.00 52318 A Remove bladder stone 9.18 NA 3.24 0.64 1.0 0.00 52320 A Remove bladder stone 9.18 NA 3.24 0.64 1.0 0.00 52320 A Cystoscopy and treatment 5.18 NA 1.71 0.37 1.0 0.00 52320 A Cystoscopy and treatment 5.18 NA 1.71 0.37 1.0 0.00 52330 A Cystoscopy and treatment 5.18 NA 1.71 </td <td>4</td> <td>Intraabdominal pressure test</td> <td>08.0</td> <td>0.27</td> <td>0.27</td> <td>0.05</td> <td>222</td> <td>52300</td> <td>¥</td> <td>Cystoscopy and treatment</td> <td>5.30</td> <td>Ϋ́Z</td> <td>2.15</td> <td>0.39</td> <td>90</td>	4	Intraabdominal pressure test	08.0	0.27	0.27	0.05	222	52300	¥	Cystoscopy and treatment	5.30	Ϋ́Z	2.15	0.39	90
4.3 909 \$2205 A Cystoscopy and treatment 5.30 NA 2.02 0.39 4.4 909 \$2210 A Cystoscopy and treatment 5.20 5.15 1.10 0.20 2.9 909 \$2211 A Remove bladder stone 6.71 13.08 2.43 0.49 3.9 909 \$2218 A Cystoscopy and treatment 4.09 NA 3.12 1.10 0.31 4.3 909 \$2220 A Cystoscopy, stone removal 6.15 NA 3.28 0.65 7.0 900 \$2320 A Cystoscopy, stone removal 6.15 NA 2.28 0.45 7.0 900 \$2320 A Cystoscopy, stone removal 6.15 NA 2.28 0.45 7.0 900 \$2320 A Cystoscopy, stone removal 5.18 NA 1.79 0.34 7.0 900 \$2320 A Cystoscopy, stone removal \$.18 NA 1.79 0.31 7.1 900 \$2320 A C	4	Us urine capacity measure	00:00	0.44	NA	00'0	XXX	52301	¥	Cystoscopy and treatment	5.50	ΝΑ	2.18	0.40	000
441 909 52313 A Cystoscopy and treatment 2.81 3.1.5 1.16 0.21 98 909 52315 A Cystoscopy and treatment 2.81 3.1.5 1.0 0.38 29 909 52317 A Remove bladder stone 6.11 13.08 2.43 0.49 38 909 52320 A Cystoscopy, stone removal 6.15 NA 3.28 0.67 710 909 52327 A Cystoscopy, stone removal 6.15 NA 2.28 0.67 106 909 52332 A Cystoscopy, stone removal 6.15 NA 2.28 0.67 106 909 52332 A Cystoscopy, stone removal 6.15 NA 2.29 0.67 107 1090 52332 A Cystoscopy, stone removal 6.15 NA 1.21 0.90 11 090 52342 A Cystoscopy and treatment 2.83 9.48 1.25 0.21 11 090 52342 A Cystoscopy and treatme	4	Revision of bladder/urethra	18.74	NA	8.30	1.43	060	52305	٧	Cystoscopy and treatment	5.30	Y.	2.02	0.39	000
080 5315 A Cystoscopy and treatment 5.20 5.13 2.00 0.38 990 52317 A Remove bladder stone 6.71 13.08 2.43 0.49 186 090 52318 A Remove bladder stone 6.71 13.08 2.43 0.49 130 090 52322 A Cystoscopy, stone removal 6.18 NA 1.79 0.54 130 090 52327 A Cystoscopy and treatment 5.18 NA 1.71 0.37 130 090 52324 A Cystoscopy and treatment 5.18 NA 1.71 0.37 131 090 52341 A Cystoscopy and treatment 5.18 NA 1.71 0.39 131 090 52341 A Cystowerper stricture tr 5.20 NA 2.17 0.39 132 090 52342 A Cysto w/racter stricture tr 5.20 NA 2.17 0.39	∢	Revision of urmary tract	19.41	ΝA	8.62	14.	060	52310	٧	Cystoscopy and treatment	2.81	3.12	1.16	0.21	900
29 90 52.11 A Remove bladder stone 0.11 13.05 2.45 0.49 36 90 53.218 A Cystoscopy and treatment 4.69 NA 1.79 0.34 36 90 53.22 A Cystoscopy, stone tranoval 6.18 NA 1.71 0.34 17 90 52.32 A Cystoscopy, stone tranoval 6.18 NA 1.71 0.34 17 90 52.32 A Cystoscopy and treatment 5.18 NA 1.71 0.37 12.1 90 52.34 A Cystoscopy and treatment 2.38 9.48 1.25 0.21 12.1 90 52.34 A Cystoscopy and treatment 2.30 NA 2.17 0.39 12.1 90 52.34 A Cystoscopy and treatment 5.20 NA 2.17 0.39 12.2 90 52.34 A Cystoscopy and treatment 5.20 NA 2.17 0.39 12.2 90 52.34 A Cystoswelper 1.5		Attach bladder/urethra	11.28	Z.	5.73	80.1	060	52315	∢ •	Cystoscopy and treatment	5.20	5.15	2.00	0.38	88
138 90 52.18 A Reference brader's force 9.16 NA 5.20 0.03 4.3 90 53.22 A Cystoscopy, stone removal 6.15 NA 1.28 0.45 1.0 90 53.22 A Cystoscopy, stone removal 6.15 NA 1.29 0.45 1.0 90 52.32 A Cystoscopy, stone removal 6.15 NA 1.29 0.45 1.0 90 52.32 A Cystoscopy, stone removal 6.15 NA 1.71 0.37 1.2 090 52.34 A Cystoscopy, stone removal 6.15 NA 1.71 0.37 1.2 090 52.34 A Cystoscopy, stone removal 4.82 NA 1.90 0.37 1.0 090 52.34 A Cystowerleaver		Attach bladder/urethra	13.60	¥;	0.60	1.29	060	52317	∢ •	Kemove bladder stone	0.71	13.08	2.43	0.49	3 8
2.2.0 A Cystoscopy and treatment 4.09 NA 1.28 0.54 7.3 90 53.22 A Cystoscopy, inject material 5.18 NA 1.71 0.37 1.5 090 53.23 A Cystoscopy, inject material 5.18 NA 1.71 0.37 1.5 090 52.33 A Cystoscopy and treatment 5.33 9.48 1.25 0.21 1.5 090 52.34 A Cystoscopy and treatment 5.83 9.48 1.25 0.37 1.2 090 52.34 A Cystoscopy and treatment 5.83 9.48 1.25 0.37 9.97 090 52.34 A Cystoscopy and treatment 5.83 9.48 1.25 0.31 9.97 090 52.34 A Cystoscopy and treatment 5.83 9.48 1.71 0.37 9.90 52.34 A Cystoscopy and treatment 5.83 NA 2.17 0.39	.	Repair bladder neck	10.07	Y S	5.08	68.0	060	52318	∢ •	Kemove bladder stone	81.6	K 2	3.28	0.07	3 8
4.3 090 53.22.2 A Cystoscopy, stoke removal 5.18 NA 1.71 0.43 1.6 090 53.23.7 A Cystoscopy and treatment 5.18 NA 1.71 0.37 1.6 090 53.33.2 A Cystoscopy and treatment 5.18 NA 1.90 0.37 1.2.1 090 53.34.4 A Cystoscopy and treatment 2.82 NA 1.91 0.31 1.2.1 090 53.24.4 A Cysto w/turster stricture tx 5.20 NA 2.17 0.39 1.3.0 090 52.34.5 A Cysto w/turster stricture tx 5.53 NA 2.30 0.43 1.6 090 52.34.5 A Cysto w/turster stricture tx 6.53 NA 2.31 0.43 1.6 0.90 52.34.6 A Cysto/uretero w/to stricture tx 6.53 NA 2.33 0.43 1.1 0.00 52.34.5 A Cysto/uretero w/to stricture tx 6.53 NA 2.33 0.43 1.0 0.00	_	Repair of bladder wound	12.49	Y :	6.49	95	060	52320	∢ .	Cystoscopy and freatment	6.09	K 7	1.19	0.34	99
1,000 1,00		Repair of bladder wound	15.69	Z Z	15.	1.43	060	52322	< <	Cystoscopy, stone removal	C1.0	# Z	17.1	0.43	9 8
1,20 1,20		Repair of bladder opening	14.0	# X	1 7 1	2.5	000	52320	< <	Contractory, mich maintain	5.18	01.4	6 1	0.37	8
23.34		Repair bladder means family	14.40	C 2	00.7	20.1	060	57337	(⊲	Cystoscopy and treatment	2 83	0.48	25.1	12.0	000
1979 1970 1972		Close bladder-uterus tistuta	17.26	K X	0.40	נננ	060	52332	< 4	Create nessage to kidney	4 82	ę z	9	0.35	000
97 990 52342 A Cysto w/up stricture tx 5.63 NA 2.30 0.43 190 900 52344 A Cysto w/renal stricture tx 6.53 NA 2.30 0.47 56 990 52344 A Cysto/wrench cystricture tx 6.53 NA 2.83 0.51 1,00 YYY 52345 A Cystownetero w/renal strict 9.02 NA 3.38 0.55 1,17 000 52352 A Cystownetero w/renal strict 9.07 NA 2.79 0.60 1,17 000 52352 A Cystownetero w/renal strict 8.7 NA 2.79 0.50 1,17 000 52352 A Cystownetero w/stome remove 6.87 NA 2.79 0.53 1,17 000 52354 A Cystownetero w/stome remove 6.87 NA 2.34 0.64 1,17 000 52354 A Cystownetero w/stome remove 6.87 N		Correction of hadder defect	30.48	Y Z	12.25	2.21	060	52341	: <	Cysto w/ureter stricture tx	5.20	N.	2.17	0.39	000
1.90 690 52343 A Cysto w/renal stricture tx 6.55 NA 2.61 0.47 3.2 690 52344 A Cysto/wretero, stricture tx 6.83 NA 2.83 0.51 6.00 52346 A Cysto/wretero, w/up stricture 8.51 NA 3.88 0.55 1.16 0.00 52346 A Cystouretero w/kread strict 9.02 NA 3.38 0.62 1.17 0.00 52351 A Cystouretero w/kread strict 6.87 NA 2.38 0.43 1.17 0.00 52353 A Cystouretero w/stone remove 6.87 NA 2.38 0.43 1.17 0.00 52354 A Cystouretero w/stone remove 6.87 NA 2.94 0.53 1.22 0.00 52354 A Cystouretero w/stone remove 8.81 NA 3.43 0.64 1.22 0.00 52354 A Cystouretero w/stone remove 8.81 NA <td></td> <td>Revision of hladder & howel</td> <td>25.20</td> <td>Ϋ́</td> <td>10.80</td> <td>1.97</td> <td>060</td> <td>52342</td> <td>٧</td> <td>Cysto w/up stricture tx</td> <td>5.63</td> <td>NA NA</td> <td>2.30</td> <td>0.43</td> <td>000</td>		Revision of hladder & howel	25.20	Ϋ́	10.80	1.97	060	52342	٧	Cysto w/up stricture tx	5.63	NA NA	2.30	0.43	000
3.2 990 52344 A Cysto/uretero, stricture ox 683 NA 283 0.51 6.6 990 52345 A Cysto/uretero with stricture 8.51 NA 3.38 0.55 1.16 000 52351 A Cystouretero wirenal stricture 9.00 5.85 NA 2.38 0.43 1.40 000 52351 A Cystouretero wirenal stricture 6.87 NA 2.79 0.50 1.17 000 52353 A Cystouretero wirenal stricture 6.87 NA 2.79 0.50 1.17 000 52354 A Cystouretero wirenamore 6.87 NA 2.79 0.50 1.22 000 52354 A Cystouretero wirenamore 6.87 NA 3.13 0.64 1.22 000 52354 A Cystouretero wirenamore 8.81 NA 3.43 0.64 1.22 000 52354 A Cystouretero wirenamore 8.81 NA 3.43 0.64 1.23 00 52354 A Cystouretero wirenamore 8.81 NA 3.43 0.64 1.24 00 52354 A Cystouretero wirenamore 8.81 NA 3.43 0.64 <		Construct bladder opening	12,44	NA	5.95	06'0	060	52343	¥	Cysto w/renal stricture tx	6.55	NA	2.61	0.47	000
66 990 52345 A Cystol/urelero w/up stricture 8.51 NA 3.38 0.55 106 YYY 52346 A Cystoureneto w/reads strict 9.02 NA 3.38 0.65 140 000 52351 A Cystoureneto w/stone 5.85 NA 2.79 0.63 1.17 000 52352 A Cystoureneto w/stone 6.87 NA 2.79 0.50 1.17 000 52353 A Cystoureneto w/stone 6.87 NA 2.94 0.53 1.22 000 52354 A Cystoureneto w/thiopsy 7.33 NA 2.94 0.53 1.23 000 52355 A Cystoureneto w/triopsy 7.33 NA 3.43 0.64 1.24 000 52355 A Cystoureneto w/triopsy more reperceed more that these values have been searched and descriptions only are copyright 2009 American Medicare, please note that these values have been stabled for Medicare payment. 1 fr values are reflected for codes 98940, 98941, and 98942, The required reducion will only be re		Laparo urethral suspension	13.26	NA	6.40	1.32	060	52344	۷	Cysto/uretero, stricture tx	6.83	Ϋ́	2.83	0.51	000
1,00 YYY 1,00 1	_	Laparo sling operation	14.77	NA	7.02	1.66	060	52345	¥	Cysto/uretero w/up stricture	8.51	NA	3.38	0.55	000
1,0 0,0 53351	۲,	Laparoscope proc, bia	00'0	0.00	0.00	0.00	YYY	52346	٧	Cystouretero w/renal strict	9.02	Y Y	3.54	0.62	000
40 000 53352	_	Cystoscopy	2.23	2.84	1.05	0.16	000	52351	۲	Cystouretero & or pyeloscope	5.85	X Y	2.38	0.43	000
1,7 0,00 53353	_	Cystoscopy, removal of clots	5.44	4.01	2.11	0.40	000	52352	Ą	Cystouretero w/stone remove	6.87	Ϋ́	2.79	0.50	000
222 000 53354 A Cystouretern whiopsy 7,33 NA 2.94 0.53 1.22 000 52355 A Cystouretern whiopsy 7,33 NA 2.94 0.53 1.27 000 52355 A Cystouretern weekerise namor 8.81 NA 3.43 0.64 1. CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 2. If values are reflected for codes not payable by Medicare, please none that these values have been established as a courtest to the general public and are not used for Medicare payment. The budget neutrality reduction from the chinopractic demonstration is not reflected in the files used for Medicare payment. The budget neutrality reduction from the chinopractic demonstration is not reflected in the files used for Medicare payment. The budget neutrality reduction from the chinopractic demonstration is not reflected in the files used for Medicare payment. The budget neutrality reduction from the chinopractic demonstration is not reflected in the files used for Medicare payment. Codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. Codes formal	_	Cystoscopy & ureter catheter	2.37	4.40	1,10	0.17	000	52353	Ą	Cystouretero w/lithotripsy	7.96	NA	3.15	0.58	000
1,22 000 52355 A Cystouretero w/excise nanor 8.81 NA 3.43 0.64 CPT codes and descriptions only are copyright 1009 American Medical Association. All Rights Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been established as a coursely to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. *Codes 100401 (2004)	_	Cystoscopy and biopsy	3.02	8.26	1.31	0.22	000	52354	<	Cystouretero w/biopsy	7.33	Ϋ́	2.94	0.53	9
for CPT		Cystoscopy & duct catheter	3.02	6.22	131	0.22	000		A	Cystouretero w/excise tumor	8.81	Ϋ́	3.43		000
for CPT	pue s	descriptions only are copyright 2009	unerican Med	ical Associal	ion. All Ríg	ghts		CPT of	odes and c	descriptions only are copyright 2009 A	American Mee	dical Associa	tion. All Rig	ıts	
for CPT	902 02	sound for codes not necessite by Modic	ton assessed	a that those	oved senter	Leiok		Reserve	d. es are refl	ected for codes not navable by Medic	are nlease no	te that these	values have b	u a	
for CPT	asac	ourtesy to the general public and are r	ot used for Me	dicare paym	ent.			establist	ned as a co	ourtesy to the general public and are n	ot used for M	fedicare payr	nent.		
	tnen	rality reduction from the chiropractic	demonstration	is not reflec	ted in the R'	/Us for CPT		The bu	idget neut	rality reduction from the chiropractic	demonstration	n is not refle	ted in the R	Us for CPT	
almacrice R VI is may not sum due to roundino	986	41, and 98942. The required reduction	n will only be	reflected in	he files used	For		Sodes 98	3940, 989	41, and 98942. The required reduction	n will only be	reflected to	the files used	tor	
	9	it. - maintenation DV/I is may not sum due	o rounding					Global	totals for	nalmactice B VI is may not sum due:	to roundino				

_	060	060	060	060	060	060	260	26	260	260	000	060	000	000	000	000	000	000	000	000	060	266		010	010	010	010	010	010	010	000	90	060	060	060	060	060	060	060					
Mal- Practice RVIs ^{2,3,4}	Ξ	0.80	1.04	1.69	0.77	0.49	0.55	60.5	600	92.0	103	70.7	0.09	0.07	0.10	0.12	0.10	0.05	0.05	90.0	0.73	8/.0	9.0	0.17	0.41	80:0	0.09	0.07	0.10	0.15	0.10	0.14	0.78	<u>-</u>	1.22	0.49	0.80	1.09	1.57	ghts	peen	VUs for CPT	d for	
Facility PE RVIs ^{2,3}	7.98	5.63	92.9	9.95	5.30	3.79	4.03	0.4	55.4	75.4	0.40	4.92	0.47	0.42	0.42	0.67	0.54	0.37	0.34	0.26	4.69	5.31	9 -	: :	5.69	1,39	1.12	1.54	1.13	137	1.70	0.0	5.27	6.42	7.44	3.98	5.39	19'9	9.27	ion. All Rig	alues have	ent. ted in the R'	he files used	
Non- Facility PE RVIIs ^{2,3}	NA	NA	N'A	Ν	NA	Y.	۲ :	Ϋ́Z	ď :	K ×	C <	K Z	0.92	90'1	NA	1.33	1.41	1.05	1.01	ΝA	37.54	35.36	9.00	2.03	AN	2.02	1.72	2.27	2.13	2.52	3.00	2.03	S Z	V.	N.	4.60	Ν	NA	N.	cal Associat	e that these v	dicare paym is not reflec	reflected in t	
Physi- clan Work RVIs.2.3	17.02	10.89	14.15	23.26	10.43	6.67	7.65	12.87	× × ×	0.10	14.00	935	177	86.0	1.28	1.62	1.35	0.71	0.72	0.76	86.6	10.68	6.00	2.20	5.33	1.26	1.23	1.26	1.26	1.95	‡ G	25.5	10.79	14.29	16.83	6.82	10.88	14.43	21.66	ierican Medi	e, please not	used for Me monstration	will only be	rounding.
Pascription	Insert uro/ves nck sphincter	Remove uro sphincter	Remove/replace ur sphincter	Remov/replc ur sphinctr comp	Repair uro sphincter	Revision of urethra	Revision of urethra	Urethrlys, transvag w/ scope	Repair of urethra injury	Repair of uretura injury	Repair of the time injury	Renair of prethra defect	Dilate urethra stricture	Dilate urethra stricture	Dilate urethra stricture	Dilate urethra stricture	Dilate urethra stricture	Dilation of urethra	Dilation of urethra	Dilation of urethra	Prostatic microwave thermotx	Prostatic of thermotx	Urology surgery procedure	Slitting of prepare	Drain penis lesion	Destruction, penis lesion(s)	Destruction, penis lesion(s)	Cryosurgery, penis lesion(s)	Laser surg, penis lesion(s)	Excision of penis lesion(s)	Disease of senis teston(s)	Bioney of penis	Treatment of nenis lesion	Treat penis lesion, graft	Treat penis lesion, graft	Treatment of penis lesion	Partial removal of penis	Removal of penis	Remove penis & nodes	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Keserved. ' If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	oreneare payment. Global totals for malpractice RVUs may not sum due to rounding.
ě	A	٧	¥	A	∢	¥	∢	∢ .	∢ .	< <	< -	< 4	: <	٧	¥	¥	¥	Y	Ą	A	∢ .	∢ (- ر	< 4	` ∢	. ∢	Ą	¥	∢	۷ ۰	ξ <	< <	< ∢	: ∢	. ∢	Y	¥	V	¥	codes and	ved. Iues are ref	ished as a c budget neu	odes 98940, 9894	al totals fo
- u				-																																				CPT	Reserved.	Stabli The I	codes	Glob
l _{E1} LGO	53445	53446	53447	53448	53449	53450	53460	53500	53502	cocsc	01000	53520	53600	53601	53605	53620	53621	53660	53661	53665	53850	53852	23899	54001	54015	54050	54055	54056	54057	54060	54100	24100	54110	54111	54112	54115	54120	54125	54130					
in the second																											0	01	0	8 8														
.,		0.38 000				0.56 090						0.17 0.10																		20.1		060 67:1		1.23 090	1.46 090		1.12 090		-			for CPT		
Mal- Practice	0.63	0.38	0.56	0.58	Ξ:	0.56	0.34	0.81	0.88	571	45.0	0.17	0.13	0.06	0.47	0.17	0.49	1.09	0.19	1.06	1.22	0.58	0.80	0.0	1.07	0.21	0.22	0.20	0.33	¥0.1	21.1	67:1	60	1.23	1.46	1.52	1.12	0.97	1.01	All Rights	s have been	the RVUs for CPT	les used for	
Facility Mal-	3.65 0.63	1.76 0.38	4.34 0.56	4.62 0.58	6.76 1.11	3.82 0.56	2.66 0.34	5.49 0.81	5.77 0.88	7.48 1.25	3.92 0.54	1.00 0.17	0.77	0.71 0.06	3.60 0.47	1.58 0.17	3.92 0.49	5.42 1.09	1.11 0.19	6.39 1.06	7.35 1.22	4.13 0.58	5.27 0.86	3.41 0.79	3.51 1.07	1.63 0.21	1.65 0.22	1.75 0.20	2.24 0.33	6.67 1.04	21.1 60.7	67:1 58:7	673 1.09	7.35 1.23	7.74 1.46	8.94 1.52	7.43 1.12	6.79	6.48 1.01	sociation. All Rights	hese values have been	payment, reflected in the RVUs for CPT	ed in the files used for	
Mal- Practice	3.65 0.63	1.76 0.38	0.56	4.62 0.58	6.76 1.11	0.56	2.66 0.34	5.49 0.81	5.77 0.88	7.48 1.25	3.92 0.54	0.17	0.77	0.71 0.06	3.60 0.47	1.58 0.17	3.92 0.49	1.09	0.19	6.39 1.06	7.35 1.22	4.13 0.58	5.27 0.86	0.0	3.51 1.07	1.63 0.21	1.65 0.22	1.75 0.20	2.24 0.33	6.67 1.04	21.1 60.7	67:1	673 1.09	7.35 1.23	7.74 1.46	8.94 1.52	7.43 1.12	6.79	6.48 1.01	tedical Association. All Rights	note that these values have been	Medicare payment,	be reflected in the files used for	ch
Facility Mal-	NA 3.65 0.63	NA 1.76 0.38	NA 4.34 0.56	4.62 0.58	NA 6.76 1.11	NA 3.82 0.56	NA 2.66 0.34	31.99 5.49 0.81	32.48 5.77 0.88	NA 7.48 1.25	NA 3.92 0.54	1.00 0.17	NA 0.77 0.13	NA 0.71 0.06	NA 3.60 0.47	2.01 1.58 0.17	NA 3.92 0.49	NA 5.42 1.09	1.42 1.11 0.19	NA 6.39 1.06	NA 7.35 1.22	NA 4.13 0.58	NA 5.2/ 0.86	3.41 0.79	NA 3.51 1.07	2.12 1.63 0.21	2.38 1.65 0.22	2.23 1.75 0.20	NA 2.24 0.33	NA 6.67 1.04	NA 7.06 1.12	67:1 58:7	NA 673 1.03	NA 7.35 1.23	NA 7.74 1.46	NA 8.94 1.52	NA 7.43 1.12	NA 6.79 0.97	NA 6.48 1.01	American Medical Association. All Rights	are, please note that these values have been	ot used for Medicare payment, demonstration is not reflected in the RVUs for CPT	n will only be reflected in the files used for	to rounding.
Physi- Non- Facility Mal- cian Facility Facility Mal- Work PE P Practice Man-23 man-23	NA 3.65 0.63	Cystourethro cut ejacul duct 5.27 NA 1.76 0.38	Incision of prostate 7.63 NA 4.34 0.56	Revision of bladder neck 8.49 NA 4.62 0.58	Prostatectomy (TURP) 15.13 NA 6.76 1.11	Remove prostate regrowth 7.65 NA 3.82 0.56	Relieve bladder contracture 4.28 NA 2.66 0.34	Laser surgery of prostate 11.15 31.99 5.49 0.81	Laser surgery of prostate 12.00 32.48 5.77 0.88	Prostate laser enucleation 17.16 NA 7.48 1.25	Dramage of prostate abscess 7.39 NA 3.92 0.54	NA 1.50 0.17	fucision of urethra (77 NA 0.77 0.13	Incision of urethra 1.13 NA 0.71 0.06	Drainage of urethra abscess 6.49 NA 3.60 0.47	Drainage of urethra abscess 2.65 2.01 1.58 0.17	6.82 NA 3.92 0.49	Drainage of urinary leakage 11.05 NA 5.42 1.09	Biopsy of urethra 2.59 1.42 1.11 0.19	NA 6.39 1.06	Removal of urethra 16.72 NA 7.35 1.22	Treatment of urethra lesion 7.53 NA 4.13 0.58	Removal of urethra lesion 10.31 NA 5.27 0.80	NA 3.88 0.75	Demousi of unsthra aland 642 NA 3.51 1.07	Treatment of urethra lesion 3.00 2.12 1.63 0.21	Treatment of urethra lesion 3.14 2.38 1.65 0.22	Removal of urethra gland 3.11 2.23 1.75 0.20	Repair of urethra defect 4.54 NA 2.24 0.33	Revise urethra, stage 1 13.98 NA 6.67 1.04	Revise urethra, stage 2 15.51 NA 7.00 1.12	17.35 NA 7.83 1.29	NA 673 1.03	Reconstruct methrs stage? 16.94 NA 7.35 1.23	Reconstruction of urethra 17.30 NA 7.74 1.46	Reconstruct urethra/bladder 21.03 NA 8.94 1.52	Male sling procedure 15.34 NA 7.43 1.12	Remove/revise male sling 13.29 NA 6.79 0.97	Insert tandem cuff 14.06 NA 6.48 1.01	kes and de	Reserved. ² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. ³ The hadoor neutrality reduction from the chirometric demonstration is not reflected in the RVUs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment: * Global totals for matpractice RVUs may not sum due to rounding.

CPT ^{1,3} /				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice		CPT'1-1		:	Physi- cian Work	Non- Facility PE	Facility PE DVI 1523	Mai- Practice	in the
HCPCS	Pom	Status		KVUs.	KVUs.	KVUS	KVUS	egois 000	ACPCS MOD	ñ	Description of the second	AT (1	9 Z	00.9	0.03	060
54135		<	Remove penis & nodes	66.17	K Z	45	2.03	060	34406	₹ •	Kemove mun-comp penns pros	17.70	5 :	(2.7	60.	000
54150		∢	Circumcision w/region! block	1.90	2.04	0.68	0.16	000	54408	₹	Repair multi-comp penis pros	13.73	Z ;	0.03	707	000
54160		٧	Circumcision, neonate	2.50	2.98	1.21	0.18	010	54410	٧	Remove/replace penis prosth	10.01	¥Z	057	60:1	969
54161		<	Circum 28 days or older	3.29	ΑN	1.77	0.25	010	54411	¥	Remov/replc penis pros, comp	18.14	۷ Z	8.40	131	960
54162		<	Lysis penil circumic lesion	3.27	3.17	1.83	0.24	010	54415	٧	Remove self-contd penis pros	8.75	Ϋ́	4.78	0.64	060
54163		. ∢	Renair of circumcision	3.27	Z	2,28	0.24	010	54416	¥	Remv/repl penis contain pros	11.87	Ϋ́	6.29	0.86	060
\$4164		: 4	Frenilotomy of penis	2.77	Y.	2.12	0.20	010	54417	٧	Remy/replc penis pros, compl	15.94	ΥZ	7.28	1.15	060
54700		(⊲	Treatment of nents lesion	80 -	157	1.03	0.08	010	54420	· •	Revision of penis	12.26	Y.Z	16.5	68'0	060
54205		(4	Treatment of penis lesion	8.84	A Z	4 70	0.00	060	54430	<	Revision of penis	10.93	A'N	5.53	0.79	060
54203		(<	Treatment of penis lesion	2.67	2 63	110	810	000	54435	: <	Revision of penis	6.71	٧Z	3.93	0.49	060
54730		(4	Drepare penis ctudy	34	- 2	0.73	0.10	000	54440	C	Repair of penis	0.00	Ϋ́	0.00	0.00	060
54231		< ⊲	Dynamic cavernosometry	20,	25	06:0	0.15	000	54450	<	Preputial stretching	1.12	89.0	0.40	80.0	000
54735		: ∢	Penile injection	61	Ξ	0.73	0.09	000	54500	Y	Biopsy of testis	1.31	NA A	0.63	60.0	000
54740		: ∢	Penis study	13	1.23	1,23	0.10	000	54505	4	Biopsy of testis	3.47	NA	1.93	0.25	010
54240	C	: <	Penis study	0.00	0.80	0.80	0.00	000	54512	4	Excise lesion testis	9.23	٧X	4.63	69.0	060
54240	3,5	. 4	Penis shidy	3	0.43	0.43	60'0	000	54520	Ą	Removal of testis	5.25	NA	3.10	0.45	060
54250	2	: ∢	Penis shidy	2.22	1.02	1.02	0.16	000	54522	٧	Orchiectomy, partial	10.15	Y.	5.06	0.74	060
54250	JL	₹ •	Penis chidy	000	0.28	0.28	100	000	54530	V	Removal of testis	8.65	NA A	4.71	0.65	060
54250	7 %	(∢	Penis study	2.22	0.74	0.74	0.15	000	54535	₹	Extensive testis surgery	13.06	N.A	6.15	0.95	060
54300	3	: ∢	Revision of nenis	11.07	NA	5.47	0.80	060	54550	*	Exploration for testis	8.31	NA NA	4.33	09:0	060
54304		: ∢	Revision of nenis	13.15	X	6.21	0.95	060	54560	¥	Exploration for testis	11.97	NA	5.73	0.87	060
54308		: ∢	Reconstruction of urethra	12.49	X	5.96	06'0	060	54600	¥	Reduce testis torsion	7.54	ΥZ	4.08	0.55	060
54317		: 4	Reconstruction of prethra	14.36	Z	6.76	1.04	060	54620	٧	Suspension of testis	5.16	ΥZ	2.57	0.37	010
54316		. ∢	Reconstruction of urethra	17.90	N.	7.95	1.30	060	54640	¥	Suspension of testis	7.57	ΑN	4.54	9.65	060
54318		<	Reconstruction of urethra	12.28	NA	6.65	99'0	060	54650	¥	Orchiopexy (Fowler-Stephens)	12.24	NA A	6.07	68.0	060
54322		<	Reconstruction of urethra	13.85	NA	6.34	1.00	060	54660	¥	Revision of testis	5.64	ΥZ	3,45	0.41	060
54324		Α.	Reconstruction of urethra	17.40	NA	1.69	1.26	060	54670	Ą	Repair testis injury	6.57	NA A	3.81	0.48	060
54326		<	Reconstruction of urethra	16.87	NA	19.7	1.22	060	54680	٧	Relocation of testis(es)	13.91	NA	6.43	101	060
54328		<	Revise penis/urethra	16.74	NA A	7.57	1.21	060	54690	٧	Laparoscopy, orchiectomy	11.60	NA NA	99.9	1.88	060
54332		۷	Revise penis/urethra	18.22	Ν	8.05	1.32	060	54692	A	Laparoscopy, orchiopexy	13.64	NA V	6.04	2.21	. 060
54336		∢	Revise penis/urethra	21.44	NA	9.38	1.55	060	54699	ပ	Laparoscope proc, testis	0.00	0.00	0.00	0.00	YYY
54340		٧	Secondary urethral surgery	9.58	NA	5.04	69'0	060	54700	¥	Drainage of scrotum	3.44	NA	2.05	0.29	010
54344		∢	Secondary urethral surgery	16.91	NA NA	7.62	1.23	060	24800	A	Biopsy of epididymis	2.33	NA	3.68	0.17	000
54348		¥	Secondary urethral surgery	18.17	NA	8.96	0.97	060	54830	¥	Remove epididymis lesion	5.91	NA	3.61	0.46	060
54352		K	Reconstruct urethra/penis	25.95	NA	10.86	1.88	060	54840	A	Remove epididymis lesion	5.22	NA:	3.02	0.39	060
54360		٧	Penis plastic surgery	12.65	NA	5.97	0.92	060	54860	Ą	Removal of epididymis	6.85	NA	3.86	0.50	060
54380		¥	Repair penis	14.03	NA	6.59	1.02	060	54861	Ą	Removal of epididymis	9.57	NA	4.95	69.0	060
54385		4	Repair penis	16.38	NA	10.10	1.83	060	54865	Ą	Explore epididymis	2.67	Y Y	3.46	0.41	060
54390		4	Repair penis and bladder	22.59	NA	09'6	1.64	060	54900	4	Fusion of spermatic ducts	14.05	A'N	7.29	0.75	060
54400		¥	Insert semi-rigid prosthesis	60'6	NA	4.58	99'0	060	54901	٧	Fusion of spermatic ducts	18,92	NA A	9.30	1.01	060
54401		∢	Insert self-coutd prosthesis	10.26	NA	6.41	0.75	060	55000	٧	Drainage of hydrocele	1.43	1.54	0.78	0.11	000
54405		٧	Insert multi-comp penis pros	14.39	NA A	6.55	1.05	060	55040	Ą	Removal of hydrocele	5.39	NA	3.26	0.45	060
	CPTc	codes an	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	ical Associa	tion, All Ri	zhts		CPT	codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associati	on. All Righ	22	
	Reserved.	ed.							Reserved	ved.			4-4-4	1	ļ	
	2 If valu	ues are r	If values are reflected for codes not payable by Medicare, please note that	re, please no	e that these	these values have been	peen		Il va	lues are rel	If values are retlected for codes not payable by Medicare, please note that these values have been senablished as a contract to the content multiple and are not used for Medicare payablt.	ire, please not	e that these v	ailles nave ox	5	
	3 The hi	shed as a	established as a courtesy to the general public and are not used for wedicare 3. The budget neutrality reduction from the chiratractic demonstration is not	emonstration	edicare payment	sted in the R	payment. reflected in the RVUs for CPT		³ The	budget neu	Stabilistica as a courtes) to the general public and are not accurate projection. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflect	ed in the RV	Js for CPT	
	codes 9	18940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflect	will only be	reflected in	ed in the files used for	1 for		sapoo	98940,989	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in th	e files used	or.	
	Medica	Medicare payment.	ent.						Medic	Medicare payment	at,					
	, Globa	al totals	diobal totals for malpractice RVUs may not sum due to rounding	o rounding.					1015	al totals ro	Global totals for malpractice $KV \cup S$ may not sum due to rounding	o rounding.				

Reserved.

Trivates are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payament.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 19840, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice R VUs may not sum due to rounding.

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Mod Spanne Control Feeling Fee	Mal- Practice RVUs ^{2,3,4}	0.19	95 1	90.0	2.0	71.0	0.00	0.53	0.11	0.11	0.20	0.13	0.04	0.10	0.00	07.0	0.0	0.04	69.0	0.80	1.18	1.42	1.68	1.62	66'0	1.93	1.20	0.18	0.39	0.27	2.53	0.30	60.0	0.13	0.20	0.86	0.10	0.18	0.34	0.08	0.17	0.08	0.11	0.77	2.20	phts		peen		VUs for CP	d for		
Mod Spanne Control Feeling Fee	Facility PE RVUs ²³	4	900	11.7	000	0.69	0.00	3,43	1.25	06.0	1.78	149	0.54	13	00	0.46	7 6	0.21	5.22	5.73	7.87	68.6	11.71	10.02	10.69	11.94	11.97	167	2.73	2.22	9.52	2.36	69.0	0.90	1.80	4.21	09'0	1.56	2.77	1.17	1.70	0.50	1.40	4.80	11.57	ion All Ri		ratues have	ent.	ted in the R	he files use		
Mod Spanne Control Feeling Fee	Facility PE RVUs ^{2,1}	06.1	4	. 2	200	2.7	0.00	ΥN	1.27	1.61	ΑN	1.61	ΥZ	1.68	35.6	200	6.50	0.40	Ϋ́	NA	Ϋ́	NA	NA	NA	NA	NA	NA	NA	Ϋ́Z	Ϋ́	NA	NA	1.28	1.65	NA	ΥN	0.88	NA	NA	1.53	2.17	1.02	1.63	Ν	Ϋ́	ical Associa		e that these	dicare paytr	is not reflec	reflected in		
Mod Spanne Control Feeling Fee	clan Work RVUs 2.3	2.58	20.75		10.01	6/1	0.00	8.31	1.46	1.41	2.86	1.99	0.68	1.55	3 03	1 100	21.1	0.55	7.35	9.55	14.67	18.81	21.61	19.47	20.48	24.57	24.65	2.79	4.83	3.90	19.75	4.26	1.50	2.05	2.99	6.74	1.50	2.70	5.13	1.27	2.63	1.20	1.71	7.35	24.43	American Med		are, please not	ot used for Me	demonstration	n will only be		o monadino.
Mod Spanne Control Feeling Fee	Description	Electroeiaculation	Chorablate prostate	Toursell production	Hanspell needle place, plos	Place it device/marker, pros	Genital surgery procedure	Place needles pelvic for rt	I & D of vulva/perineum	Drainage of gland abscess	Surgery for vulva lesion	Lysis of labial lesion(s)	ffymenotomy	Destroy valva lesions sim	Destroy anites legionic normal	Discuss varied resistant compi	Diopsy of varya politicum	Biopsy of vulva/perineum	Partial removal of vulva	Complete removal of vulva	Extensive vulva surgery	Extensive vulva surgery	Extensive vulva surgery	Extensive vulva surgery	Extensive vulva surgery	Extensive vulva surgery	Extensive vulva surgery	Partial removal of hymen	Remove vagina gland lesion	Repair of vagina	Repair clitoris	Repair of perineum	Exam of vulva w/scope	Exam/biopsy of vulva w/scope	Exploration of vagina	Drainage of pelvic abscess	Drainage of pelvic fluid	1 & d vaginal hematoma, pp	I & d vag hematoma, non-ob	Destroy vag lesions, simple	Destroy vag lesions, complex	Biopsy of vagina	Biopsy of vagina	Remove vagina wall, partial	Remove vagina tissue, part	descriptions only are convirult 2009. A	Consulation of the second consulations	Rected for codes not payable by Medica	ourtesy to the general public and are n	trality reduction from the chiropractic	941, and 98942. The required reduction	н.	Clobal totale for malma stice D VI le may not our due to remaine
Mod Spanne Control Feeling Fee	Status	٧	. 4	; -	۲.	∢	Ü	٧	A	Ą	¥	¥	K	×	: <	۲ -	ς -	∢ :	K	¥	ĸ	٧	4	¥	¥	4	٧	4	¥	4	٧	4	4	¥	<	¥	٧	K	¥	¥	¥	٧	٧	¥	٧	des and	_	s are ref	ed as a c	lget neu	940,989	: paymer	totale for
Mod Spanne Aum Ferting	Mod																																													CPT co	Reserved	If value	stablish	The buc	odes 98	Medicare	Clakel
8 Mod Status Description Work Profession Pealiny Profession Mod Profession Pealiny Profession Mod Profession <td>CPT¹³/ HCFCS</td> <td>55870</td> <td>55873</td> <td>1000</td> <td>0.000</td> <td>228/0</td> <td>55899</td> <td>55920</td> <td>56405</td> <td>56420</td> <td>56440</td> <td>56441</td> <td>56442</td> <td>10595</td> <td>10000</td> <td>20273</td> <td>20002</td> <td>26606</td> <td>56620</td> <td>56625</td> <td>56630</td> <td>56631</td> <td>56632</td> <td>56633</td> <td>56634</td> <td>56637</td> <td>56640</td> <td>56700</td> <td>56740</td> <td>26800</td> <td>56805</td> <td>56810</td> <td>56820</td> <td>56821</td> <td>57000</td> <td>57010</td> <td>57020</td> <td>57022</td> <td>57023</td> <td>57061</td> <td>57065</td> <td>57100</td> <td>57105</td> <td>57106</td> <td>57107</td> <td>-</td> <td></td> <td>. 67</td> <td>•</td> <td>r.</td> <td>•</td> <td>~</td> <td>7</td>	CPT ¹³ / HCFCS	55870	55873	1000	0.000	228/0	55899	55920	56405	56420	56440	56441	56442	10595	10000	20273	20002	26606	56620	56625	56630	56631	56632	56633	56634	56637	56640	56700	56740	26800	56805	56810	56820	56821	57000	57010	57020	57022	57023	57061	57065	57100	57105	57106	57107	-		. 67	•	r.	•	~	7
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and a second	Mai- Practice RVUs ^{23,4}	0.67	0.50	-	17.0	0.50	0.45	0.63	0.44	0.94	0.33	0.24	0.25	0.62	0.02	700	0.00	10.1	0.46	0.51	1.23	0.51	0.00	0.50	0.63	0.91	0.40	61.0	0.34	0.33	0.56	0.72	1.42	1.86	2.15	2.37	1.14	1.24	1.79	1.92	2.25	1.13	1.44	1.77	2.36	tion All Rights	0	values have been	neat.	cted in the R VUs for CPT	the files used for		
and a second	Facility Mai- PE Practice RVUs ^{2,3} RVUs ^{2,3,4}	4.63 0.67	166 050	100	1.00 0.11	3.65 0.50	3.48 0.45	4.52 0.63	3.48 0.44	6.02 0.94	2.63 0.33	2.44 0.24	1.41 0.25	4 32 0.62	2000 2000	250 42.7	00.0	4.63	3.35 0.46	3.93 0.51	5.15 1.23	3.87 0.51	0.00 0.00	3.87 0.50	4.71 0.63	6.04 0.91	3.26 0.40	1.07 0.19	2.30 0.34	3.40 0.33	3,99 0.56	5.29 0.72	8.68 1.42	10.13 1.86	12.15 2.15	13.16 2.37	7.02 1.14	7.50 1.24	10.32 1.79	10.92 1.92	12.17 2.25	6.93 1.13	10.36 1.44	10,26 1.77	13.11 2.36	ical Association All Rights		ote that these values have been	fedicare payment.	n is not reflected in the R VUs for CPT	e reflected in the files used for		
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 | 92.5. N. 13.54 19.0 9733.0 A Regular balded variant keison 13.11 NA 6.0 20.25 N.A 13.54 19.0 99.0 573.0 A Pergular vagina 13.7 NA 1.6 20.25 N.A 13.54 1.6 19.0 574.15 A Pergular vagina 22.7 NA 1.6 21.8 1.6 1.6 1.0 90.0 574.2 A Pergular vagina 2.4 NA 1.9 1.0 2.8 2.13 1.6 1.0 1.0 90.0 574.2 A Pergular vagina keope 2.4 NA 1.0 1.0 9.4 NA 1.0 1.0 <td>Y Z</td> <td></td> <td>< <</td> <td>58150</td> <th>060</th> <td>0.55</td> <td>4.24</td> <td>NA:</td> <td>7.55</td> <td>Repair urethrovaginal lesion</td> | Y Z | | < < | 58150 | 060 | 0.55
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 | 8.18 N.A. 4.15 1.01 900 574.10 A Kamove again foreign body 2.44 1.04 <
 | 818 NA 475 101 900 57421 A Ramone vaginal foreign body 244 NA 178 101 900 57421 A Exam floopy of rag, wiscope 201 103 004 900 57423 A Exam floopy of rag, wiscope 120 173 0.96 6.75 N.9 0.18 0.01 0.04 0.00 57423 A Raman bopsy of rag, wiscope 120 1.73 0.96 0.85 0.13 0.04 0.00 57423 A Raman bopsy of rag, wiscope 1.80 1.73 0.96 0.85 0.13 0.04 0.00 57423 A Raman bopsy of rag, wiscope 1.80 1.73 0.96 0.86 0.05 0.00 57424 A Raman of cervix wiscope 1.93 1.04 0.00 1.60 1.88 1.05 0.01 0.00 57424 A Raman of cervix wiscope 1.93 1.04 1.00 1.74 1.74 1.74 1.74 </td <td>3.3.7 NA 1.450 1.47 0.00 57410 A Pelvic examination 137 NA 0.99 8.18 NA 4.75 1.01 0.00 57421 A Remove vagian from the party of 244 NA 1.09 0.00</td> <td>28.35 NA 1364 361 960 57440 A Debic examination 173 NA 104 8.18 NA 4456 147 90 57415 A Remove vaginal foreign body 224 NA 158 8.18 NA 4456 147 900 57420 A Remove vaginal foreign body 244 NA 159 2.84 2.01 169 0.08 57420 A Remove vaginal foreign body 244 NA 159 2.84 2.01 169 0.08 57420 A Remove vaginal foreign body 160 173 0.59 0.32 0.04 0.00 57420 A Remove vaginal foreign body 160 173 0.59 0.34 0.04 0.00 57420 A Remove vaginal foreign body 160 173 0.59 0.03 0.04 0.00 57420 A Remove vaginal foreign body 160 174 174</td> <td>c 18.33 NA 19.06 99.00 57335 A Repair vagina 19.87 NA 11.44 11.44 11.44 11.45 11.47 10.00 57410 A Debric examination 17.5 NA 11.49 11.44 NA 14.54 14.74 10.00 57421 A Debric examination 24.4 NA 14.55 16.4 10.01 11.44 NA 14.55 16.4 10.01 57421 A Debric examination 24.4 NA 14.55 16.0 11.3 0.15 11.44 NA 14.55 16.0 11.3 0.15 17.3 NA 15.0 0.00 57421 A Debric examination 17.3 NA 17.4 NA 17.4</td> <td>6 1323 NA 1346 137 690 57330 A Regate Valeder-Vagina belon 1311 NA 606 8 1323 NA 134 136 190 57400 A Polition of Vagina 227 NA 134 966 8023 NA 1450 147 600 57416 A Polyte examination 127 NA 159 100 969 57420 A Polyte examination 179 NA 159 100 100 97421 A Polyte examination 179 NA 159 100 97421 A Polyte examination 179 100 97421 A Polyte examination 179 100 97421 A Polyte examination 179</td> <td>Ϋ́Z</td> <td></td> <td>¥.</td> <td>58145</td> <th>060</th> <td>2.76</td> <td>9.44</td> <td>NA</td> <td>17.02</td> <td>istula repair & colostomy</td> | 3.3.7 NA 1.450 1.47 0.00 57410 A Pelvic examination 137 NA 0.99 8.18 NA 4.75 1.01 0.00 57421 A Remove vagian from the party of 244 NA 1.09 0.00 0.00 0.00
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 | 0.88 | 4.44 | NA | 7.74 | evise vag graft via vagina |
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 | 174 NA 444 0.88 090 58100 A Biopsy of uterus liming 1.53 1.23 0.73 8.56 NA 7.81 2.10 090 58110 A Bitton and cuertage 3.54 2.89 1.96 15.24 NA 5.51 1.10 090 58120 A Myomectomy adom method 15.69 NA 771 17.02 NA 5.17 0.90 58145 A Myomectomy adom method 15.69 NA 771 17.02 NA 5.76 0.90 58145 A Myomectomy adom complex 20.24 8.97 17.52 NA 5.76 0.90 58146 A Myomectomy adom complex 20.24 NA 4.97 17.53 NA 4.24 0.90 58150 A Total hysterectomy 17.21 NA 8.27 8.81 NA 5.04 0.64 0.90 58152 A Total hysterectomy 21.73 NA 10.14
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90.0 57415 A Pelvice examination 17.5 NA 6.99 8.18 NA 14.50 1.01 900 57415 A Remove vagual foreign body 244 NA 1.58 2.88 2.13 1.69 0.16 0.10 57423 A Beam of vagua wiscope 1.03 0.74 1.74 0.74 2.68 2.13 1.69 0.11 0.00 57423 A Beam of vagua wiscope 1.03 0.74 1.05 0.17 1.74 0.74 0.74 0.00 57423 A Beam of vagua wiscope 1.03 0.74 1.74 0.74 0.00 57423 A Beam of vagua wiscope 1.03 0.74 0.00 57454 A Beam of vagua wiscope 1.03 0.74 0.00 57454 A Beam of vagua wiscope 1.03 1.01 0.00 57456 A Beam of vagua wiscope 1.03 1.17 1.04 1.00 0.00 <td>28.2 NA 13.64 3.61 990 57440 A Disinon of vaginal 12.7 NA 11.4 8.18 NA 41.50 1.47 990 57410 A Perhic examination 1.75 NA 1.71 8.18 NA 41.50 1.61 900 57415 A Remove again fronting body 2.44 NA 1.75 1.61 1.89 1.89 1.80</td> <td>c 1533 NA 1543 NA 1546 NA 1548 NA 1548 NA 1548 NA 1548 NA 1548 NA 1548 164 000 57410 A Replace accumulation 175 NA 114 NA 1450 161 000 57420 A Remove equal foreign body 174 NA 198 NA 198 NA 104 2.44 2.01 1.04 0.00 57421 A Remove equal foreign body 1.44 NA 1.95 0.01 0.00 57421 A Remove equal foreign body 1.44 NA 1.14 NA 1.95 0.01 0.00 57421 A Remove equal foreign body 1.44 NA 1.14 NA 1.45 NA 1.95 0.01 0.00 57421 A Remove occurs 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00</td> <td>83.5 NA 1364 137 090 57330 A Repair balder-vaginal lesion 1311 NA 602 23.2 NA 1364 140 090 57335 A Repair vaginal serion 137 NA 140 140 090 57410 A Petpair vaginal foreign body 2.27 NA 140 140 090 57410 A Petpair vaginal foreign body 2.44 NA 145 101 139 0.05 1.33 0.05 1.34 NA 1.36 1.34 NA 1.34 NA 1.34 NA 1.34 NA 1.35 NA 1.38 1.34 NA 1.34 NA 1.34 NA 1.34 NA 1.44 NA 1.34 NA 1.34 NA 1.34 NA 1.34 NA 1.34 NA 1.34 NA</td> <td>0.74</td> <td></td> <td>∢ ·</td> <td>57800</td> <th>060</th> <td>19.0</td> <td>7,34</td> <td>NA</td> <td>13.91</td> <td>onstruct vagina with graft</td> | 28.2 NA 13.64 3.61 990 57440 A Disinon of vaginal 12.7 NA 11.4 8.18 NA 41.50 1.47 990 57410 A Perhic examination 1.75 NA 1.71 8.18 NA 41.50 1.61 900 57415 A Remove again fronting body 2.44 NA 1.75 1.61 1.89 1.89 1.80 | c 1533 NA 1543 NA 1546 NA 1548 NA 1548 NA 1548 NA 1548 NA 1548 NA 1548 164 000 57410 A Replace accumulation 175 NA 114 NA 1450 161 000 57420 A Remove equal foreign body 174 NA 198 NA 198 NA 104 2.44 2.01 1.04 0.00 57421 A Remove equal foreign body 1.44 NA 1.95 0.01 0.00 57421 A Remove equal foreign body 1.44 NA 1.14 NA 1.95 0.01 0.00 57421 A Remove equal foreign body 1.44 NA 1.14 NA 1.45 NA 1.95 0.01 0.00 57421 A Remove occurs 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
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 | 19.0 | 7,34 | NA | 13.91 | onstruct vagina with graft |
| 0.67 090 57800
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 | 8.18 N.A. 4.73 1.01 990 5/413 A Remove equal storing body 2.44 N.A. 1.29 2.48 2.11 1.69 0.18 0.10 5/423 A Remove equal storing body 1.24 N.A. 1.29 2.68 2.13 1.69 0.18 0.10 5/423 A Repair paragin brough body 1.24 1.35 0.73 6.79 N.A. 3.76 0.04 0.00 5/423 A Repair paragin brough body 1.24 0.35 0.73 0.74 6.79 N.A. 3.76 0.04 0.00 5/423 A Repair paragin brough body 1.24 0.34 0.74 <td< td=""><td>818 NA 4.75 101 990 57415 A Remove vagual foreign body 2.44 NA 1.58 2.44 2.13 1.01 990 57420 A Exam of vagual foreign body 2.44 NA 1.38 2.44 2.13 1.69 0.16 0.10 57420 A Exam of vagual foreign body 2.44 NA 1.35 2.55 0.29 0.24 0.04 0.00 57422 A Remove vagual foreign body 1.60 1.73 0.96 0.59 0.24 0.04 0.00 57422 A Remove vagual foreign body 1.60 1.73 0.96 0.89 0.34 0.06 0.00 57452 A Repair parvage defect, lap 16.00 NA 1.74 1.09 0.34 0.06 0.00 57452 A Repair parvage defect, lap 16.00 NA 1.75 1.09 0.34 0.06 0.00 57452 A Repair parvage defect, lap</td><td>93.7.7 NA 14.50 17.1 90.0 57415 A Permine angula fine plant 17.5 NA 19.9 8.18 NA 14.50 1.01 900 57415 A Remore vagual fine plant 1.74 NA 1.98 2.68 2.13 1.69 0.16 0.00 57421 A Exambiopsy of vag wiscope 1.00 1.33 0.04 2.68 2.13 1.69 0.01 57421 A Exambiopsy of vag wiscope 1.00 1.33 0.04 6.75 NA 3.76 0.44 0.00 57422 A Exambiopsy of vag wiscope 1.00 1.74 1.00 6.25 0.54 0.04 0.00 57452 A Exambiopsy of vag wiscope 1.01 1.74</td><td>28.25 NA 13.64 3.61 990 57410 A Diabrico of vagina 2.27 NA 11.4 8.03 NA 475 1.47 990 57410 A
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 | g 53 5 NA 1364 137 090 57330 A Repair balder-vaginal lesion 1311 NA 602 28 25 NA 136 190 090 57335 A Repair vaginal foreign body 137 NA 140 090 57410 A Perice administron 2.27 NA 140 090 57410 A Repair vaginal foreign body 2.44 NA 145 161 090 57420 A Remove vaginal foreign body 2.44 NA 140 000 090 57421 A Remove vaginal foreign body 2.44 NA 140 000 17420 A Remove vaginal foreign body 2.44 NA 150 0.14 000 57421 A Remove vaginal foreign body 2.44 NA 1.56 0.14 000 57421 A Remove vaginal foreign body 2.44 NA 1.56 0.14 0.05 57421 A Remove vaginal foreign body 2.44 NA 1.48 0.73 0.74 NA 1.48 0.74 0.74 NA 1.48 0.74 0.74 0.74 <td>V S</td> <td></td> <td>∢ ·</td> <td>57720</td> <th>060</th> <td>1.09</td> <td>4.89</td> <td>NA</td> <td>8.54</td> <td>onstruction of vagina</td> | V S | | ∢ · | 57720 | 060
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 | 1971 | 69.9 | NA | 14.25 | pair paravag defect, open |
| (6f) 090 57550 1.33 090 57555 1.19 090 57558 1.19 090 57700 0.92 090 57700 0.88 090 58100 2.10 090 58110 2.10 090 58140 2.76 090 58146 2.76 090 58146 2.76 090 58146 2.76 090 58146 2.77 090 58150 2.76 090 58150 2.77 090 58150 2.77 090 58180 2.77 090 58180 2.77 090 58180 2.77 090 58180
 | (6f) 090 57550 1.33 090 57555 1.19 090 57556 1.19 090 57700 0.92 090 57700 0.88 090 57700 2.10 090 58100 2.10 090 58110 2.11 090 58140 2.14 090 58146 2.15 090 58146 2.16 090 58146 2.17 090 58146 2.15 090 58150 2.24 090 58150 2.25 090 58180 2.25 090 58180
 | 14.25 NA 6.69 1.61 090 57550 A Removed of residual cervix 6.24 NA 4.02 11.15 NA 5.73 1.33 090 57556 A Remove cervix.repair vagina 9.24 NA 5.72 11.20 NA 6.13 0.90 57556 A Remove cervix.repair vagina 9.24 NA 5.16 12.00 NA 6.13 0.90 57556 A Remove cervix.repair bowel 9.26 NA 5.16 12.00 NA 6.13 0.92 0.90 57700 A Revision of cervix 4.22 NA 5.16 13.91 NA 4.44 0.89 0.90 57700 A Revision of cervix 4.53 NA 3.48 13.91 NA 4.44 0.88 0.90 57800 A Bevision of cervix 4.53 NA 3.19 15.44 NA 7.34 0.67 0.90 57800 A
 | 14.25 NA 6.69 1.61 090 57550 A Removed of residual carvix 6.24 NA 4.02 11.22 NA 5.73 1.33 090 57556 A Removed cervix, repair vagina 9.24 NA 5.42 11.20 NA 5.97 1.19 090 57756 A Remove cervix, repair bowel 1.69 1.42 1.16 12.00 NA 6.17 0.00 57700 A Rewision of cervix 4.22 NA 3.48 12.04 NA 6.13 0.90 57700 A Revision of cervix 4.22 NA 3.48 13.91 NA 7.34 0.67 0.90 57700 A Revision of cervix 4.53 NA 3.19 17.44 NA 4.44 0.88 0.90 57100 A Bollation of cervical stand 0.77 0.47 0.74 0.74 15.44 NA 4.44 0.88 0.90 58110 <td>8.18 N.A 4.75 1.01 090 5/415 A Kemove vagual rocting Mody 2.44 N.A 1.50 2.64 2.13 1.69 0.16 0.10 0.10 0.14 A Exam of vagual wiscope 2.20 1.73 0.96 2.68 2.13 1.69 0.18 0.00 57423 A Repair paravag defect, lap 1.60 NA 7.45 6.5 0.59 0.21 0.04 0.00 57423 A Repair paravag defect, lap 1.60 NA 7.45 6.87 N.A 3.46 0.06 0.00 57423 A Leganic paravag defect, lap 16.00 NA 7.45 6.87 N.A 3.46 0.06 0.00 57423 A Leganic paravag defect, lap 16.01 NA 7.45 6.93 0.05 0.06 0.00 57453 A Laparoccopy, sucp, colopery 1.50 1.71 1.71 1.44 N.A 3.50 0.68</td> <td> S. /td> <td>30.37
 NA 13.04 13</td> <td>28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 8.13 NA 13.64 3.61 080 57410 A Petrice examination 1.75 NA 0.99 8.13 NA 4.75 1.01 090 5742 A Exam of vagina w/scope 1.60 1.33 0.73 2.68 2.13 1.69 0.18 0.10 57423 A Exam of vagina w/scope 1.60 1.33 0.73 6.79 N.A 3.76 0.44 0.00 57423 A Exam of vagina w/scope 1.60 1.73 0.73 6.79 N.A 3.76 0.44 0.00 57423 A Exam of vagina forcept 1.60 1.73 0.74 6.79 N.A 3.76 0.44 0.00 57423 A Exam of vagina forcept 1.60 1.73 0.74 6.79 N.A 3.76 0.44 0.00</td> <td>c 15.38 NA 7.53 190 090 57735 A Repair vagina 1987 NA 9.66 2.8.22 NA 1.364 3.61 090 57400 A Dilation of vaginal foreign body 2.27 NA 1.14 8.1.8 NA 4.75 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16 0.10 57423 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.69 0.18 0.19 57423 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.04 0.00 57423 A Remove vaginal foreign body 2.44 NA 1.58 0.55 0.29 0.01 0.00 57423 A Remove vaginal foreign body 2.24 NA 1.38 0.55 0.59 0.04 0.00 57423</td> <td>28.2 NA 13.64 1.37 090 57330 A Repair bidded-vagina lesion 13.11 NA 6.02 15.3.8 NA 1.364 1.37 090 57335 A Repair vagina 1.31 NA 9.66 15.3.8 NA 1.364 3.61 090 57410 A Petvic examination 1.17 NA 9.09 3.0.7 NA 14.50 1.47 090 57410 A Petvic examination 1.17 NA 9.09 2.0.8 2.13 1.69 0.16 0.10 57420 A Evance vagina discripted 1.77 NA 1.14 2.68 2.13 1.69 0.18 0.10 57421 A Evance vagina discripted 1.24 NA 1.14 2.68 2.13 1.69 0.18 0.10 57421 A Evance vagina freety back 1.27 NA 1.14 2.68 0.21 0.04 0.00 57421</td> <td>Ϋ́</td> <td></td> <td>¥</td> <td>57545</td> <th>060</th> <td>1.43</td> <td>6.04</td> <td>NA</td> <td>11.58</td> <td>olpopexy, intraperitoneal</td> | 8.18 N.A 4.75 1.01 090 5/415 A Kemove vagual rocting Mody 2.44 N.A 1.50 2.64 2.13 1.69 0.16 0.10 0.10 0.14 A Exam of vagual wiscope 2.20 1.73 0.96 2.68 2.13 1.69 0.18 0.00 57423 A Repair paravag defect, lap 1.60 NA 7.45 6.5 0.59 0.21 0.04 0.00 57423 A Repair paravag defect, lap 1.60 NA 7.45 6.87 N.A 3.46 0.06 0.00 57423 A Leganic paravag defect, lap 16.00 NA 7.45 6.87 N.A 3.46 0.06 0.00 57423 A Leganic paravag defect, lap 16.01 NA 7.45 6.93 0.05 0.06 0.00 57453 A Laparoccopy, sucp, colopery 1.50 1.71 1.71 1.44 N.A 3.50 0.68
 | S. | 30.37 NA 13.04 13.04 13.04 13.04 13.04 13.04 13.04 13.04
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 | 28.2 NA 13.64 1.37 090 57330 A Repair bidded-vagina lesion 13.11 NA 6.02 15.3.8 NA 1.364 1.37 090 57335 A Repair vagina 1.31 NA 9.66 15.3.8 NA 1.364 3.61 090 57410 A Petvic examination 1.17 NA 9.09 3.0.7 NA 14.50 1.47 090 57410 A Petvic examination 1.17 NA 9.09 2.0.8 2.13 1.69 0.16 0.10 57420 A Evance vagina discripted 1.77 NA 1.14 2.68 2.13 1.69 0.18 0.10 57421 A Evance vagina discripted 1.24 NA 1.14 2.68 2.13 1.69 0.18 0.10 57421 A Evance vagina freety back 1.27 NA 1.14 2.68 0.21 0.04 0.00 57421 | Ϋ́ | | ¥ | 57545 | 060
 | 1.43 | 6.04 | NA | 11.58 | olpopexy, intraperitoneal |
| 1,4,3 090 57545 1,61 090 57550 1,33 090 57555 1,07 090 57558 1,19 090 57700 1,02 090 57700 1,08 090 57700 1,09 090 58100 2,10 090 58140 2,17 090 58144 2,76 090 58145 3,54 090 58145 3,55 090 58145 3,54 090 58145 3,54 090 58150 3,55 090 58150 3,57 090 58180 4 090 58180 5 58180 1
 | 143 090 57545 161 090 57550 133 090 57556 107 090 57558 139 090 5758 092 090 57720 052 090 57720 054 090 57800 251 090 5810 210 090 5812 211 090 5814 217 090 5814 213 090 5814 214 090 5815 215 090 5815 214 090 5815 213 090 5815 214 090 58180 215 090 58180
 | 11.58 NA 6.04 14.3 090 57545 A Remove cervis/repair pelvis 14.00 NA 6.99 14.25 NA 6.69 1.61 090 57550 A Remove cervis/repair agina 6.24 NA 4.02 11.6.2 NA 6.07 1.07 090 57556 A Remove cervis/repair agina 9.84 NA 5.42 12.00 NA 6.07 1.07 090 57556 A Remove cervis/repair bowel 9.26 NA 5.16 12.00 NA 6.07 1.07 090 57758 A Remove cervis, repair bowel 9.26 NA 5.16 12.00 NA 6.07 1.09 090 57720 A Revision of cervis 4.22 NA 3.19 13.91 NA 7.34 0.67 090 57720 A Revision of cervis 4.53 NA 3.19 17.4 NA 7.34 0.67 090 57720 A Revision of cervis 7.71 0.74 0.7
 | 11.58 NA 6.04 1.43 0.00 57545 A Remove cervix/repair pelvis 14.00 NA 6.99 14.25 NA 6.04 1.43 0.00 57555 A Remove cervix/repair pelvis 14.00 NA 4.02 11.25 NA 6.07 1.07 0.90 57555 A Remove cervix/repair bowel 9.24 NA 5.42 12.00 NA 5.97 1.19 0.90 57556 A Remove cervix/repair bowel 9.26 NA 5.16 12.01 NA 6.07 1.07 0.90 57750 A Remove cervix/repair bowel 9.26 NA 5.16 13.01 NA 6.07 1.09 0.90 57770 A Revision of cervix 13.01 NA 7.34 0.67 0.90 57770 A Revision of cervix 13.01 NA 7.34 0.67 0.90 57770 A Bridose of cervical canal 15.4 NA 4.44 0.88 0.90 58110 A Bridose of cervical canal 15.24 NA 5.51 1.10 0.90 58110 A Bridose of cervical canal 15.24 NA 5.51 1.10 0.90 58120 A Myomectomy abdom method 15.69 NA 7.71 17.02 NA 5.76 1.34 0.90 58146 A Myomectomy abdom complex 20.24 NA 9.31 17.02 NA 2.76 0.90 58146 A Myomectomy abdom complex 20.24 NA 8.27 17.01 17.02 17.02 0.90 58146 A Total hysterectomy 17.02 17.02 17.02 17.02 17.02 17.02 17.03 17.03 17.03 17.03 17.03 17.04 17.04 17.05 17.04 17.04 17.04 17.04 17.05 17.04 17.05 17.05 17.05 17.05 17.05 17.04 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05 17.05
 | 8.18 N.A 4.73 1.01 090 5/415 A Kennove vagatal rode vagatal rode of carrix 2.44 N.A 1.10 2.64 2.10 1.59 0.16 0.10 0.16 0.10 5/423 A Exam of vagata wiscope 2.20 1.73 0.96 2.68 2.13 1.69 0.18 0.00 5/423 A Repair paravag defect, lap 1.60 N.A 7.45 6.5 0.59 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 N.A 7.45 6.9 0.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 N.A 7.45 6.9 0.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 0.83 0.9 0.34 0.06 0.00 5/453 A Bactory correction of cervix wiscope 1.33 1.71 1.73 0.81 1.6 1.88 1.05 0.01 0.00 5/455 A Bactory of cervix wiscope 1.34 <td> State</td> <td>30.37 NA 13.04 13</td> <td>28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 3.037 NA 13.64 3.61 080 57450 A Petric examination 1.75 NA 0.99 3.037 NA 4.75 1.01 090 57420 A Petric examination 1.75 NA 0.99 2.44 2.01 1.04 0.00 57420 A Exam Of vegina wiscope 2.40 1.33 0.73 2.58 2.13 1.69 0.18 0.10 0.00 57421 A Exam Of vegina wiscope 1.73 0.96 6.75 0.21 0.04 0.00 57423 A Rambópos of vega wiscope 1.73 0.96 6.79 1.03 0.04 0.00 57423 A Rambópos of vega wiscope 1.73 0.74 6.79 1.03 0.04 0.00 57452 A Exam Of cervix wiscope 1.79 NA</td> <td>c 15.38 NA 7.53 1.90 990 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64
 3.61 990 5740 A Diffusion of Vagina 1.73 NA 1.14 30.37 NA 1456 1.01 990 57416 A Delivica of Vagina NA 1.73 NA 1.14 NA 1.73 NA 1.73 NA 1.74 NA 1.74 NA 1.74 NA 1.74 NA 1.73 NA 1.74 1.74 NA 1.74 N</td> <td>c 18.25 NA 13.64 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 15.38 NA 1.54 1.50 090 57335 A Repair bladder-vagina 13.11 NA 9.66 15.38 NA 1.54 1.60 090 57410 A Pelvic examination 1.75 NA 1.14 8.18 NA 4.75 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.05 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.13 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.14 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.14 2.58 0.59 0.18 0.10 57421 A</td> <td>Ϋ́N</td> <td></td> <td>∀</td> <td>57540</td> <th>060</th> <td>16.0</td> <td>4.83</td> <td>N.</td> <td>7.84</td> <td>olpopexy, extraperitoneal</td> | State | 30.37 NA 13.04
 13.04 13 | 28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 3.037 NA 13.64 3.61 080 57450 A Petric examination 1.75 NA 0.99 3.037 NA 4.75 1.01 090 57420 A Petric examination 1.75 NA 0.99 2.44 2.01 1.04 0.00 57420 A Exam Of vegina wiscope 2.40 1.33 0.73 2.58 2.13 1.69 0.18 0.10 0.00 57421 A Exam Of vegina wiscope 1.73 0.96 6.75 0.21 0.04 0.00 57423 A Rambópos of vega wiscope 1.73 0.96 6.79 1.03 0.04 0.00 57423 A Rambópos of vega wiscope 1.73 0.74 6.79 1.03 0.04 0.00 57452 A Exam Of cervix wiscope 1.79 NA | c 15.38 NA 7.53 1.90 990 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 990 5740 A Diffusion of Vagina 1.73 NA 1.14 30.37 NA 1456 1.01 990 57416 A Delivica of Vagina NA 1.73 NA 1.14 NA 1.73 NA 1.73 NA 1.74 NA 1.74 NA 1.74 NA 1.74 NA 1.73 NA 1.74 1.74 NA 1.74 N
 | c 18.25 NA 13.64 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 15.38 NA 1.54 1.50 090 57335 A Repair bladder-vagina 13.11 NA 9.66 15.38 NA 1.54 1.60 090 57410 A Pelvic examination 1.75 NA 1.14 8.18 NA 4.75 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.05 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.13 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.14 2.48 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.14 2.58 0.59 0.18 0.10 57421 A | Ϋ́N | | ∀ | 57540 | 060 | 16.0
 | 4.83 | N. | 7.84 | olpopexy, extraperitoneal |
| 1.91 090 57540 1.43 090 57545 1.43 090 57550 1.33 090 57556 1.07 090 57586 0.02 090 57720 0.03 090 57720 0.04 090 58100 2.10 090 5810 2.17 090 5814 2.17 090 5814 2.17 090 5814 2.16 090 5814 2.16 090 5814 2.16 090 5814 2.16 090 5814 2.17 090 5814 2.16 090 5814 2.17 090 5814 2.17 090 5815 2.17 090 5815 2.17 090 58180
 | 1.91 090 57540 1.43 090 57545 1.61 090 57580 1.33 090 57586 1.19 090 57586 0.22 090 57720 0.67 090 57720 0.68 090 58100 2.10 090 5810 2.11 090 5814 2.17 090 5814 2.76 090 5814 2.76 090 5814 2.76 090 5814 2.76 090 5814 2.76 090 5814 2.76 090 5814 2.76 090 5814 2.77 090 5814 2.77 090 5814 2.76 090 5814 2.77 090 5818
 | 7.84 NA 4.83 0.91 0.90 57540 A Removal of residual cervix 13.19 NA 6.68 11.58 NA 6.04 1.43 0.90 57545 A Removal of residual cervix 13.19 NA 6.99 11.52 NA 6.04 1.61 0.90 57550 A Removal of residual cervix 1.40 NA 6.94 11.52 NA 6.07 1.03 0.90 57556 A Removal of residual cervix 9.84 NA 5.42 10.05 NA 6.13 0.90 57556 A Removal of residual cervix 1.69 NA 5.16 12.09 NA 5.97 1.99 0.90 57700 A Revision of cervix 4.22 NA 3.48 12.69 NA 4.44 0.88 0.90 57700 A Revision of cervix 4.23 NA 3.19 1.54 NA 4.44 0.88 0.90 57700 A Revision of cervix 4.23 NA 3.14
 | 7.84 NA 4.83 0.91 090 57540 A Removal of residual carvix 13.19 NA 6.68 11.28 NA 6.04 1.43 090 57545 A Removal of residual carvix 13.19 NA 6.99 11.22 NA 6.04 1.61 090 57555 A Removal of residual carvix 14.00 NA 6.99 11.52 NA 5.73 1.33 090 57555 A Removal of residual carvix 1.40 NA 5.92 10.36 NA 5.91 1.07 090 57756 A Remove cervix/repair pebris 6.24 NA 5.16 1.200 NA 5.97 1.09 090 57756 A Remove cervix/repair pebris 6.24 NA 5.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.16 1.17 1.16 1.17 1.
 | 8.18 N.A. 4.75 1.01 090 5/415 A Kemove vagatal rough Rody 2.44 N.A. 1.05 2.84 2.13 1.69 0.16 0.10 5/423 A Exam of vagata w/scope 2.20 1.73 0.96 2.84 2.13 1.69 0.18 0.10 5/423 A Repair paravag defect, lap 16.00 NA 7.45 45 6.59 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 16.00 NA 7.45 5 0.59 1.03 0.04 0.00 5/422 A Repair paravag defect, lap 16.00 NA 7.45 5 0.89 1.03 0.04 0.00 5/422 A Exam of cervix w/scope 1.50 1.24 0.85 6 0.89 1.03 0.04 0.00 5/452 A Bx/curet of cervix w/scope 1.59 1.17 1.17 6 0.89 0.01 0.01 5/456 A Bx/curet of cervix w/scope 1.89 1.53 1
 | State | 30.37 NA 13.04 OR 57410
 A Petric examination 1.75 NA 0.99 8.18 NA 4150 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16 0.10 57420 A Remove vaginal foreign body 2.44 NA 1.58 2.68 2.13 1.69 0.18 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.68 2.13 1.69 0.18 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.59 0.17 0.90 6.57 0.59 0.21 0.04 0.00 57421 A Remove vaginal wiscope 1.20 1.73 0.96 6.79 NA 3.74 0.00 57452 A Remove vaginal wiscope 1.70 1.74 1.74 1.74 1.74 1.74 1.74 1.74 | 28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 8.187 NA 14.50 147 090 57410 A Petrice examination 1.75 NA 0.99 8.18 NA 4.75 1.01 090 57420 A Exam of vagina w/scope 2.44 NA 1.58 2.84 2.01 1.59 0.18 0.10 57421 A Exam of oppose 2.40 1.33 0.73 2.88 2.13 1.69 0.18 0.10 57423 A Exam of oppose 1.60 1.73 0.73 6.79 NA 3.76 0.04 0.00 57423 A Exam of oppose 1.60 1.73 0.74 6.79 NA 3.76 0.04 0.00 57423 A Exam of oppose 1.50 1.73 0.96 6.79 NA 3.74 A Exam of oppose 1.50 1. | c 15.38 NA 7.53 1.90 990 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 990 57410 A Dilation of vagina 1.73 NA 1.14 30.37 NA 1456 1.01 990 57415 A Remove vaginal foreign body 2.44 NA 1.73 NA 1.18 2.44 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.13 0.96 2.84 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.85 2.13 1.69 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 0.55 0.21 0.04 0.00 57421 A Remove vaginal foreign body 2.44 NA 1.13 0.04 0.01 0.01 0.00
 | e 13.54 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 8.15.38 NA 1.36 1.37 0.90 57400 A Repair bladder-vagina lesion 13.11 NA 9.66 28.25 NA 1.36 3.01 0.90 57400 A Repair bladder-vagina lesion 13.11 NA 9.66 3.03.7 NA 1.450 1.00 0.90 57410 A Repair vagina 1.75 NA 1.14 2.44 2.01 1.59 0.10 0.90 57420 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.10 0.00 57421 A Remove vaginal foreign body 2.44 NA 1.38 2.65 0.21 0.04 0.00 57421 A Remove vaginal foreign body 2.44 NA 1.13 0.55 0.59 0.21 0.04 0.00 0.00 <td>NA</td> <td></td> <td>A</td> <td>57531</td> <th>060</th> <td>1.89</td> <td>7.84</td> <td>NA</td> <td>16.62</td> <td>spension of vagina</td> | NA | | A | 57531 | 060
 | 1.89 | 7.84 | NA | 16.62 | spension of vagina |
| 189 090 57531 391 090 57540 43 090 57545 161 090 57555 163 090 57556 133 090 57556 139 090 57556 130 090 57700 130 090 57700 140 090 58100 210 090 58110 211 090 58140 217 090 58146 216 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 218 090 58146 212 090 58180 212 090 58180 212
 | 189 090 57531 391 090 57540 43 090 57545 161 090 57555 163 090 57556 133 090 57556 139 090 57556 130 090 57700 130 090 57700 140 090 58100 2210 090 58110 211 090 58140 276 090 58146 276 090 58146 276 090 58146 276 090 58146 276 090 58146 276 090 58146 277 090 58146 276 090 58146 277 090 58146 275 090 58146 276 090 58180 277 090 58180
 | 16.62 NA 7.84 1.89 090 57531 A Removal of cerviv, radical 29.77 NA 14.43 1.84 NA 6.48 1.81 090 57546 A Removal of residual cervix 13.19 NA 6.68 1.15.8 NA 6.69 1.61 090 57556 A Remova cervix/repair pelvis 6.24 NA 6.69 1.15.2 NA 6.69 1.61 090 57555 A Remove cervix/repair pelvis 6.24 NA 6.69 1.15.2 NA 6.91 1.60 90 57555 A Remove cervix/repair pelvis 6.24 NA 5.42 1.2.0 NA 6.13 090 57556 A Remove cervix/repair pelvis 1.42 NA 5.42 1.2.0 NA 6.13 0.90 57556 A Remove cervix/repair pelvis 1.42 NA 5.42 1.2.0 NA 6.13 0.90 57538 A
 | 1662 NA 734 189 990 57531 A Removal of cerviva, radical 29.77 NA 1443 744 NA 488 0.90 57540 A Removal of residual cervix 13.19 NA 6.68 11.58 NA 6.69 1.61 0.90 57550 A Remove cervix/repair pelvix 6.24 NA 6.69 11.22 NA 5.73 1.33 0.90 57555 A Remove cervix/repair pelvix 6.24 NA 6.69 10.56 NA 5.73 1.33 0.90 57556 A Remove cervix/repair vagina 9.84 NA 5.16 12.00 NA 5.97 1.19 0.90 57556 A Remove cervix/repair vagina 9.84 NA 5.16 12.00 NA 5.13 0.90 57750 A Remove cervix/repair vagina 9.84 NA 5.16 13.91 NA 5.13 0.90 57720 A
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| 162 090 57530 189 090 57531 181 090 57540 183 090 57545 161 090 57545 163 090 57556 119 090 57756 109 090 57700 110 090 57700 288 090 58100 210 090 58100 210 090 58140 211 090 58140 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 214 090 58146 215 090 58152 214 090 58152 215 090 58180 215 090 58180
 | 162 990 57530 189 990 57531 181 990 57540 183 990 57545 183 990 57545 183 990 57555 184 990 57556 189 990 57700 189 990 57700 180 990 57800 281 990 58100 210 990 58100 211 990 58140 212 990 58140 214 990 58140 215 990 58140 216 990 58140 217 900 58140 217 900 58140 218 990 58150 214 900 58150 215 990 58180 216 990 58180
 | 13.57 NA 6.86 1.62 090 57330 A Removal of cervix. 5.19 NA 3.47 16.62 NA 7.84 1.89 090 57331 A Removal of cervix, radical 2.17 NA 6443 16.62 NA 4.83 090 57345 A Removal of residual cervix 13.19 NA 6.99 11.58 NA 6.04 1.43 090 57350 A Removal of residual cervix 12.00 NA 6.99 11.22 NA 6.09 1.61 090 57550 A Removal of residual cervix 6.24 NA 6.99 11.22 NA 5.77 1.19 090 57556 A Removal of residual cervix 6.24 NA 5.16 10.36 NA 5.97 1.19 090 57556 A Removal of residual cervix 6.24 NA 5.16 12.00 NA 5.97 1.19 090 5755
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 | 68'0 | 4.72 | NA | 7.47 | pair of bowel bulge |
| 189 990 57522 162 990 57330 188 990 57531 191 990 57545 143 990 57545 141 990 57545 133 990 57556 134 990 57556 107 990 57756 108 990 57700 109 57700 57700 109 58100 57100 210 990 58110 211 990 58146 217 990 58146 216 990 58146 217 990 58146 217 990 58146 216 990 58146 217 990 58146 217 990 58146 217 990 58180 217 990 58180 218 990 58180 21<
 | 189 990 57522 162 990 57530 188 990 57531 191 990 57545 143 990 57545 133 990 57545 133 990 5755 113 990 5755 107 990 57750 108 990 57700 109 57700 57700 110 990 58100 211 990 58100 211 990 58146 211 990 58146 216 990 58146 217 990 58146 216 990 58146 217 990 58146 217 990 58146 217 990 58146 217 990 58180
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 | 8.18 NA 4.73 1.01 090 5/415 A Kennove vaganal rotting Mody 2.44 NA 1.20 2.68 2.13 1.69 0.16 0.10 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 4s 6.79 NA 3.76 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 NA 7.45 6s 0.29 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 NA 7.45 6s 0.89 1.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 NA 7.45 6s 0.89 1.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 0.04 0.08 6s 0.09 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 6s 0.09 5/452 A Ram of cervix wiscope 1.50 1.24 0.85 1.60 1.88 1.03<
 | State | 30.37 NA 13.54 13.0 13.0
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 | 0.33 | 1.80 | NA | 4.88 | ert mesh/pelvic flr addon |
| 0.3.3 2.2.2 57520 8.8 090 57521 8.8 090 57531 1.4.3 090 57540 1.4.3 090 57540 1.4.3 090 57545 1.4 090 57550 1.3 090 57550 1.19 090 57550 1.19 090 57720 0.07 57720 57700 0.09 57720 57700 1.10 090 58110 2.17 090 58140 2.17 090 58146 2.17 090 58146 2.17 090 58146 2.17 090 58146 2.17 090 58146 2.17 090 58146 2.18 090 58146 2.18 090 58180 2.18 090 58180 2.18 090 58180 <th>0.3.3 ZZZ 57520 8.8 090 57521 8.8 090 57521 1.8.1 090 57531 1.9.2 090 57540 1.1.3 090 57545 1.1.3 090 57556 1.1.9 090 57556 1.1.9 090 57750 0.00 57700 57700 0.00 57700 57700 0.1.1 090 5810 1.1.1 090 5810 1.1.1 090 58146 2.76 090 58146 2.77 090 58146 2.78 090 58146 2.76 090 58146 2.77 090 58146 2.78 090 58146 2.78 090 58146 2.78 090 58180 2.78 090 58180 2.88 090 58180</th> <th>4.88 NA 1.80 0.33 2222 57520 A Conization of cervix 4.06 3.56 2.89 2.80 1.3.77 NA 4.72 0.89 0.90 57520 A Conization of cervix 3.62 2.94 2.49 1.3.7 NA 6.86 1.62 0.90 57530 A Removal of cervix, radical 2.9.77 NA 3.49 1.5.8 NA 6.91 1.69 0.90 57540 A Removal of cervix, radical 2.9.77 NA 1.443 1.5.8 NA 6.99 1.63 0.90 57540 A Removal of cervix, radical 2.9.77 NA 6.68 1.1.58 NA 6.99 1.69 57540 A Removal of cervix, radical 2.9.77 NA 6.68 1.1.58 NA 6.99 1.69 57550 A Removal of cervix, radical 2.9.77 NA 6.49 1.44 1.44 1.44 1.44 0.90 575</th> <td>4.88 NA 1.80 0.33 2222 57520 A Conization of cervix 4.06 3.56 2.89 2.89 1.89 0.90 57520 A Conization of cervix 4.06 3.50 2.94 2.49 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.94 2.49 2.49 2.94 2.49 2.44 3.43 2.94 2.49 2.94 2.49 2.44 3.41 3.41 3.41 3.41 3.41 3.41 3.41 3.42 3.49 3.42 3.43 3.42 3.43 3.42 3.43 3.42 3.43 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42 3.42</td> <td>8.18 NA 4.73 1.01 090 5/415 A Kennove vagual rough body 2.44 NA 1.03 2.48 2.01 1.59 0.16 0.10 5/421 A Exam of vagual wiscope 2.20 1.73 0.73 2.68 2.13 1.69 0.18 0.10 5/421 A Repair awy, scope 2.20 1.73 0.96 6.55 0.59 0.21 0.04 0.09 5/423 A Repair capt, sug, colopoexy 1.50 1.73 0.96 ce 0.89 1.03 0.34 0.06 0.00 5/452 A Require parvage defect, lap 1.60 1.74 0.85 ce 0.89 1.03 0.04 0.09 5/452 A Require parvage defect, lap 1.60 1.74 0.85 ce 0.89 1.03 0.04 0.09 5/452 A Bacturet of cervix wiscope 1.24 0.85 ce 0.89 0.31 0.01 5/456 A Bacturet of cervix wiscope 1.59 1.61 <t< td=""><td> State</td><td>30.37 NA 13.04 50.0 57410 A Petroce examination 1.75 NA 0.99 8.18 NA 4.75 1.01 090 57416 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16 0.10 57421 A Exam of vagina wiscope 2.04 NA 1.58 2.68 2.13 1.69 0.10 57421 A Exam of vagina wiscope 2.00 1.73 0.96 0.56 0.59 0.21 0.04 0.00 57423 A Remove vaginal foreign body 2.44 NA 1.58 0.56 0.19 0.10 57421 A Exam of vagone 2.00 1.73 0.96 0.57 0.54 0.04 0.00 57423 A Repair parvas wiscope 1.50 1.73 0.96 0.89 0.21 0.04 0.00 57423 A Repair parvas wiscope 1.50 1.73</td><td>28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 8.13 NA 14.50 14.7 090 57410 A Petrice examination 1.75 NA 0.19 8.18 NA 4.75 1.01 090 57415 A Petrice examination 2.44 NA 1.99 2.44 2.01 1.59 0.16 0.00 57421 A Exam of vagina w/scope 1.60 1.33 0.73 2.68 2.13 1.69 0.18 0.10 57421 A Exam of vagina w/scope 1.60 1.33 0.73 6.75 NA 3.76 0.04 0.00 57423 A Exam of opensory of vag w/scope 1.60 1.73 0.74 6.75 NA 3.76 0.04 0.00 57423 A Exam of opensory of vag w/scope 1.50 1.77 1.17 1.03 0.34 0.06 0.00 5742</td><td>e 15.38 NA 7.53 1.90 990 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.54 3.61 990 5740 A Diffulon of Vagina 1.73 NA 9.99 30.37 NA 1450 1.47 990 57410 A Remove vaginal foreign body 2.44 NA 1.73 NA 1.78 NA 1.78</td><td>c 13.24 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 28.25 NA 7.54 1.90 090 57400 A Repair bladder-vagina lesion 13.11 NA 9.66 28.25 NA 1.36 1.90 090 57410 A Repair vagina 1.75 NA 9.66 30.37 NA 1.450 1.01 090 57410 A Remove vaginal foreign body 2.44 NA 1.78 NA 1.14 2.44 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.58 2.13 1.09 0.00 57421 A Remove vaginal foreign body 2.44 NA 1.45 0.59 0.21 0.04 0.00</td><td>1.66</td><td>×</td><td>∢</td><td>57513</td><th>060</th><td>1.91</td><td>7.54</td><td>NA</td><td>15.86</td><td>ensive repair of vagina</td></t<></td>
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 | 1.75 | 7.00 | NA | 14.36 | pair of vagina |
| 1.75 090 57511 1.91 090 57513 1.33 222 57520 1.89 090 57530 1.89 090 57531 2.91 090 57545 1.41 090 57545 1.41 090 57545 1.31 090 57556 1.19 090 57556 1.19 090 57700 1.09 090 57700 2.10 090 57700 2.11 090 58100 2.10 090 58146 2.11 090 58146 2.14 090 58146 2.16 090 58146 2.17 090 58146 2.17 090 58146 2.16 090 58146 2.16 090 58146 2.17 090 58146 2.17 090 58180
 | 1.75 090 57511 1.91 090 57513 1.93 222 57520 1.89 090 57530 1.89 090 57531 1.91 090 57531 1.41 090 57545 1.43 090 57545 1.41 090 57545 1.13 090 5755 1.19 090 5755 1.09 090 5770 1.09 090 5770 1.10 090 5770 2.10 090 5780 2.11 090 5780 2.11 090 5810 2.11 090 5810 2.12 090 5814 2.13 090 5814 2.14 090 5814 2.15 090 5814 2.16 090 5814 2.17 090 5815 <t< th=""><th>14.36 NA 7.00 1.75 0.90 57511 A Cryocautery of cervix 1.92 1.70 1.40 4.88 NA 7.34 1.91 0.90 57513 A Lace strangery of cervix 1.92 1.76 1.40 4.88 NA 1.80 0.30 57520 A Conization of cervix 4.06 2.94 2.49 1.57 NA 4.72 0.89 0.90 57520 A Conization of cervix 4.06 1.40 1.44 3.47 1.57 NA 4.78 1.99 0.90 57530 A Removal of cervix 4.09 2.94 2.49 1.54 NA 4.81 1.99 0.90 57540 A Removal of cervix 3.19 NA 6.88 1.44 3.47 1.15 NA 4.83 0.90 57550 A Removal cervix/repair powel 2.14 0.0 2.40 2.49 2.49 2.49 2.49 2.49</th><td>14.36 NA 7.00 1.75 090 37511 A Cryocautery of cervix 1.92 1.70 1.40 15.86 NA 7.34 1.91 0.90 57513 A Lace straggery of cervix 1.92 1.66 1.40 15.86 NA 1.80 0.90 57520 A Conization of cervix 4.06 2.94 2.49 15.77 NA 4.82 0.90 57520 A Removal of cervix 4.06 2.94 2.49 16.22 NA 7.84 1.89 0.90 57530 A Removal of cervix 4.06 2.94 2.49 16.22 NA 7.84 1.89 0.90 57530 A Removal of cervix 5.19 NA 4.43 16.22 NA 6.09 57530 A Removal of cervix 1.43 0.90 57550 A Removal of cervix 1.40 NA 4.42 1.44 1.44 1.44 1.44 1.44</td><td>8.18 NA 4.73 1.01 090 5/415 A Kemore vagual rocting Mody 2.44 NA 1.20 2.64 2.10 1.59 0.16 0.10 5/421 A Repair paravag defect, lap 1.60 1.73 0.96 4.5 0.5 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 4.5 0.5 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 5.0 0.89 1.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 6.9 0.89 0.06 0.00 5/423 A Repair paravag defect, lap 1.60 1.74 0.85 0.91 0.63 0.06 0.00 5/452 A Baran of cervix wiscope 1.23 0.17 1.17 1.60 1.88 1.05 0.01 0.00 5/452 A Buckery devery wiscope 1.39 1.31 1.17</td><td>0.00 3.4 7.4 1.8 1.8 2.44 2.01 1.59 0.16 0.10 57420 A Examof vaginal foreign body 2.44 NA 1.59 0.16 0.10 57420 A Examof vaginal foreign body 2.44 NA 1.59 0.16 0.10 57420 A Examof vagina w/scope 1.60 1.33 0.73 2.58 2.13 1.69 0.18 0.10 57423 A Examofopsy of vag w/scope 1.50 1.73 0.74 ds 6.79 N.A 3.76 0.44 0.90 57423 A Examofopsy of vag w/scope 1.50 1.74 3.60 ds 0.39 0.04 0.90 57423 A Examofopsy of vag w/scope 1.50 1.74 3.60 ds 0.90 57423 A Examofopsy of vag w/scope 1.50 1.74 3.82 ds 0.09 0.00 57452 A Examofopsy of vag w/scope 1.50 1.85</td><td>30.37 NA 13.04 OS 57410 A Petric examination 1.75 NA 0.99 8.18 NA 4.75 1.01 990 57415 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.64 2.01 1.59 0.16 0.10 57421 A Remove vaginal foreign body 2.44 NA 1.58 2.68 2.13 1.69 0.18 0.10 0.00 57421 A Remove vaginal
foreign body 2.44 NA 1.58 0.96 6.55 0.59 0.21 0.04 0.00 57421 A Repair paravag defect, lap 1.60 1.73 0.96 6.79 NA 3.76 0.44 0.00 57422 A Baran of coervix wiscope 1.59 1.71 0.96 6.79 NA 3.14</td><td>28.25 NA 13.64 3.61 080 57400 A Dilation of vagina 2.27 NA 1.14 3.037 NA 14.50 1.47 090 57410 A Petive examination 1.75 NA 0.99 3.037 NA 4.75 1.01 090 57420 A Petive examination 1.75 NA 0.99 2.48 2.01 1.01 090 57420 A Exam of vagina w/scope 1.60 1.33 0.73 2.68 2.13 1.69 0.18 0.10 57421 A Exam of vagina w/scope 1.70 1.73 0.96 5.74 0.59 0.21 0.04 0.00 57423 A Exam b/oppsy of vag w/scope 1.73 0.96 6.79 NA 3.76 0.04 0.00 57425 A Exam of vagina w/scope 1.73 0.96 6.79 NA 3.76 0.04 0.00 57425 A Exam of vagin w/scop</td><td>c 15.38 NA 7.53 1.90 990 573.55 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 990 574.00 A Dilation of vagina 1.73 NA 9.96 30.37 NA 145.0 1.47 990 574.10 A Dilation of vagina 1.73 NA 1.14 8.18 NA 4.75 1.01 990 574.15 A Remove vaginal foreign body 2.44 NA 1.78 0.99 2.44 2.01 1.59 0.16 0.10 574.21 A Remove vaginal foreign body 2.44 NA 1.88 1.60 1.73 0.96 1.88 1.60 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.73 0.96 1.74 N <td< td=""><td>e 13.54 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 28.25 NA 1.36 1.30 090 57400 A Repair vagina 1.31 NA 9.66 28.27 NA 1.36 3.61 090 57400 A Repair vagina love gain 1.37 NA 9.66 30.37 NA 14.50 1.47 090 57410 A Rebair vagina love igna 2.27 NA 1.14 2.44 NA 14.50 1.01 090 57410 A Remove vaginal foreign body 2.44 NA 1.38 0.99 2.64 2.01 1.59 0.16 0.10 57421 A Remove vaginal dovelgan wiscope 1.20 1.33 0.96 2.65 0.21 0.04 0.00 57421 A Remove vaginal dovelgan wiscope 1.00 1.33 0.96 6.79 0.21 0.04 0.00 57421</td><td>1.42</td><td></td><td>¥</td><td>57510</td><th>060</th><td>1.39</td><td>5.88</td><td>NA</td><td>11.42</td><td>pair rectum & vagina</td></td<></td></t<> | 14.36 NA 7.00 1.75 0.90 57511 A Cryocautery of cervix 1.92 1.70 1.40 4.88 NA 7.34 1.91 0.90 57513 A Lace strangery of cervix 1.92 1.76 1.40 4.88 NA 1.80 0.30 57520 A Conization of cervix 4.06 2.94 2.49 1.57 NA 4.72 0.89 0.90 57520 A Conization of cervix 4.06 1.40 1.44 3.47 1.57 NA 4.78 1.99 0.90 57530 A Removal of cervix 4.09 2.94 2.49 1.54 NA 4.81 1.99 0.90 57540 A Removal of cervix 3.19 NA 6.88 1.44 3.47 1.15 NA 4.83 0.90 57550 A Removal cervix/repair powel 2.14 0.0 2.40 2.49 2.49 2.49 2.49 2.49
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 | 8.18 NA 4.73 1.01 090 5/415 A Kemore vagual rocting Mody 2.44 NA 1.20 2.64 2.10 1.59 0.16 0.10 5/421 A Repair paravag defect, lap 1.60 1.73 0.96 4.5 0.5 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 4.5 0.5 0.21 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 5.0 0.89 1.03 0.04 0.00 5/423 A Repair paravag defect, lap 1.60 1.73 0.96 6.9 0.89 0.06 0.00 5/423 A Repair paravag defect, lap 1.60 1.74 0.85 0.91 0.63 0.06 0.00 5/452 A Baran of cervix wiscope 1.23 0.17 1.17 1.60 1.88 1.05 0.01 0.00 5/452 A Buckery devery wiscope 1.39 1.31 1.17
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| 1,35 0,90 57510 1,15 0,90 57511 1,15 0,90 57513 2,22 0,90 57513 2,8 0,90 57523 2,8 0,90 57534 4,3 0,90 57549 4,3 0,90 57549 5,13 0,90 57549 7,13 0,90 57556 7,13 0,90 57558 7,10 0,90 5758 7,10 0,90 5758 7,10 0,90 58140 7,11 0,90 58140 7,11 0,90 58145 7,12 0,90 58145 7,14 0,90 58145 7,15 0,90 58145 7,16 0,90 58145 7,17 0,90 58145 7,18 0,90 58145 7,18 0,90 58145 7,18 0,90 58145 7,18 0,90 58145 7,18 0,90 58145 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 7,18 0,90 58155 8,18 0,90 58155 9,18 0,90 58155 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90 1,19 0,90 0,90
 | 1339 090 57510 175 090 57511 191 090 57513 183 090 57513 184 090 57520 185 090 57530 184 090 57540 184 090 57540 185 090 57545 187 090 57556 188 090 57556 199 690 57750 205 57700 57700 205 67700 57700 110 090 57700 206 57700 57700 210 090 57700 211 090 58140 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58146 217 090 58152
 | 1142 NA 588 139 090 57510 A Cauterization of cervix 190 142 106 15.86 NA 736 139 090 57511 A Contaction of cervix 1.92 1.40 1.40 15.86 NA 736 1.91 090 57520 A Contaction of cervix 1.92 1.60 1.40 4.88 NA 4.89 090 57520 A Contaction of cervix 1.90 1.40 1.40 1.357 NA 6.86 1.62 090 57520 A Contaction of cervix 1.90 1.40 1.40 1.357 NA 6.86 1.62 090 57530 A Removal of cervix 1.90 NA 1.44 <t< th=""><td>11.42 NA 588 139 090 57510 A Cantertzation of cervix 1.90 1.42 1.06 18.45 NA 7.00 1.75 .090 57511 A Caveration of cervix 1.92 1.70 1.40 15.86 NA 7.30 1.75 .090 57521 A Conization of cervix 1.92 1.70 1.40 1.88 NA 1.80 .031 .090 57522 A Conization of cervix 4.06 3.56 2.80 1.57 NA 1.89 .090 57530 A Conization of cervix 4.06 3.47 1.44 4.06 3.47 1.44 4.06 3.47 1.44 3.47 1.44 3.47 1.44 3.47 1.44 3.47 1.44 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47 3.47</td><td>8.18 NA 4.75 1.01 090 5/415 A Kemore vagual rough body 2.44 NA 1.20 2.48 2.01 1.59 0.16 0.10 5/421 A Exam of vagual wiscope 2.20 1.73 0.96 6.55 0.59 0.21 0.04 0.00 5/421 A Repair pairway defect, lap 1.60 1.73 0.96 6.5 0.59 0.21 0.04 0.00 5/423 A Repair pairway defect, lap 1.60 1.73 0.96 6.5 0.59 0.24 0.00 5/425 A Repair pairway defect, lap 1.60 NA 7.45 6.0 0.89 1.03 0.34 0.06 0.00 5/452 A Exam of cervix wiscope 1.50 1.24 0.85 6.9 0.6 0.00 5/454 A Bacturett of cervix wiscope 1.51 1.17 1.17 6.0 1.89 1.01 0.01 5/456 A Bacturett of cervix wiscope 1.59 1.61 0.81 <t< td=""><td> State</td><td>30.37 NA 13.54 50.0 57410 A Petrice examination 1.75 NA 0.99 2.44 NA 4.75 1.01 090 57416 A Remove vaginal foreign body 2.44 NA 1.58 2.44 2.01 1.59 0.16
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| 118 010 57421 504 000 57423 504 000 57423 506 000 57424 506 000 57455 511 010 57454 512 090 57454 513 090 57461 520 5760 57461 53 090 5750 51 090 5751 51 090 5751 51 090 5751 62 090 5751 63 090 5753 64 090 5753 65 090 5753 66 090 5754 67 090 5754 68 090 5755 69 5750 5754 60 5750 5750 70 70 7750 70 70 7750 70 70
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 | 2.68 2.13 1.69 0.18 0.01 574.21 A Repair parawage defect, lap 1.03 0.04 6.57 N.A. 3.75 0.44 0.09 574.23 A Bay wiscope 1.53 0.04 6.59 N.A. 3.75 0.04 0.09 574.24 A Bay wiscope 1.53 1.73 0.04 0.89 0.05 0.00 574.24 A Bay wiscope 1.23 1.73 1.74 1.74 1.74 1.74 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 0.00 574.60 A Bay of cervix wiscope, leep 1.34 1.35 1.35 1.35 1.35 1.35 1.34 1.35 1.34 1.34 1.34 1.35 1.34 1.35 1.34 1.35 1.34 1.35 1.34 1.35 1.34 1.34 1.34 1.31 1.34 1.34 1.31 1.34 1.34
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 | 8.18 NA 4.75 1.01 090 5/415 A Kemove vaginal foreign body 2.44 NA 1.50
 | 8.18 NA 4.75 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.58 | 3.37
 | 28.25 NA 13.64 3.61 0.90 57400 A Dilation of vagina 2.27 NA 1.14 30.37 NA 14.50 1.47 0.90 57410 A Pelvic examination 1.75 NA 0.99 8.18 NA 4.75 1.01 0.90 57415 A Remove vaginal foreign body 2.44 NA 1.58 | e 15.38 NA 7.53 1.90 090 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 90 57400 A Dilation of Vagina 2.27 NA 1.14 3.37 NA 14.50 1.47 090 57410 A Petric examination 1.75 NA 0.99 8.18 NA 4.75 1.01 090 57415 A Remove vaginal foreign body 2.44 NA 1.58
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 | 0.16 | 1.59 | 2.01 | 2.44 | move vagina lesion |
| 1, 0, 0, 0, 0, 0, 0, 0,
 | 116 010 57420 018 010 57421 024 000 57423 036 000 57423 036 000 57424 037 037 57454 031 000 57454 031 000 57456 038 090 57460 039 57461 57461 040 57461 57461 123 090 57511 131 090 57511 131 090 57511 131 090 57521 131 090 57531 132 090 57531 133 090 57545 143 090 57546 143 090 57540 134 090 57540 135 090 57540 134 090 57540 135 090 57540 134
 | 2.44 2.01 1.59 0.15 0.10 57420 A Rambol Oygun wiscope 1.03 0.13 0.13 0.14 2.84 2.01 1.69 0.18 0.10 57420 A Rambologo of vag wiscope 2.00 1.33 0.74 6.57 0.45 0.04 0.00 57422 A Rambologo of vag wiscope 1.50 1.74 0.84 6.79 1.05 0.04 0.00 57422 A Bandocopy vag wiscope 1.50 1.74 0.85 1.60 1.88 1.05 0.01 0.00 57453 A Bandocopy vag wiscope 1.50 1.74 0.85 4.54 N.A 3.64 0.00 57456 A Bandocopy vag wiscope 1.50 1.75 1.75 1.74 N.A 1.60 1.75 1.75 1.75 1.74 N.A 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.75 1.
 | 244 201 159 0.16 0.10 57420 A Rambolopy of vag wiscope 2.0 1.50 0.13 0.04 0.55 0.59 0.18 0.01 0.04 0.00 57423 A Rambolopy of vag wiscope 2.0 1.0 0.04 0.55 0.59 0.01 0.04 0.00 57423 A Rambolopy of vag wiscope 2.0 1.3 0.04 0.89 1.03 0.04 0.00 57423 A Rambolopy of vag wiscope 1.0 0.04 0.90 1.04 0.00 0.00 57454 A Rambolopy of vag wiscope 1.0 0.08 0.01 1.08 0.01 0.00 57456 A Rambolopy of vag wiscope 1.0 0.08 4.34 NA 3.00 0.08 0.00 57460 A Rambolopy of cervix wiscope 1.0 1.0 4.34 NA 3.00 0.08 0.00 57460 A Rambolopy of cervix wiscope 2.0 1.0 4.34 NA 3.00 0.09 <td></td> <td></td> <td>20,22 NA 14,50 1,47 090 57410 A Pelvic examination 1,75 NA 0.99</td> <td>28.25 NA 13.64 3.61 090 57400 A Dilation of vagina 2.27 NA 1.14 30.37 NA 14.50 1.47 090 57410 A Pelvic examination 1.75 NA 0.99</td> <td>e 15.38 NA 7.53 1.90 690 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 690 57400 A Dilation of vagina 2.27 NA 1.14 30.37 NA 14.50 1.47 690 57410 A Pelvic examination 1.75 NA 0.99</td> <td>28.25 NA 13.64 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 e 15.38 NA 7.33 1.90 090 57345 A Repair bladder-vagina lesion 19.87 NA 9.66 28.25 NA 13.64 3.61 090 57400 A Dibtitoto of vagina 2.27 NA 1.14 30.37 NA 14.50 14.7 090 57410 A Pelvic examination 1.75 NA 0.99</td> <td>Y N</td> <td></td> <td>Y</td> <td>57415</td> <th>060</th> <td>101</td> <td>4.75</td> <td>NA</td> <td>8.18</td>
<td>sure of vagina</td> |
 | | 20,22 NA 14,50 1,47 090 57410 A Pelvic examination
1,75 NA 0.99 | 28.25 NA 13.64 3.61 090 57400 A Dilation of vagina 2.27 NA 1.14 30.37 NA 14.50 1.47 090 57410 A Pelvic examination 1.75 NA 0.99 | e 15.38 NA 7.53 1.90 690 57335 A Repair vagina 19.87 NA 9.66 28.25 NA 13.64 3.61 690 57400 A Dilation of vagina 2.27 NA 1.14 30.37 NA 14.50 1.47 690 57410 A Pelvic examination 1.75 NA 0.99
 | 28.25 NA 13.64 1.37 090 57330 A Repair bladder-vagina lesion 13.11 NA 6.02 e 15.38 NA 7.33 1.90 090 57345 A Repair bladder-vagina lesion 19.87 NA 9.66 28.25 NA 13.64 3.61 090 57400 A Dibtitoto of vagina 2.27 NA 1.14 30.37 NA 14.50 14.7 090 57410 A Pelvic examination 1.75 NA 0.99 | Y N | | Y | 57415 | 060
 | 101 | 4.75 | NA | 8.18 | sure of vagina |

CPT ¹³ /	}	i	P. A. and a different	Physical clan Work	Non- Facility PE PVIIs ^{2,3}	Facility PE BVII-23	Mai- Practice	Global	CPT ¹³ /	Mod Status	us Description	- L	Physi- clan Work ?VUs ^{2,3}	Non- Facility PE RVUs ^{2,3}	Facility PE RVUs ^{2,3} F	Mai- Practice tVUs ^{23,4}	9
58200	ě	A	Extensive hysterectomy	23.00	NA	10.73	2.05	060		¥	Hysteroscop	sp proc	3.33	2.90	1.55	0.22	-
58210		. ∢	Extensive hysterectomy	30.76	NA	14.36	2.36	060	58558	٩	A Hysteroscopy, biopsy	· .	4.74	3.85	2.12	0.31	
58240		. ∢	Removal of pelvis contents	49.02	NA	22.40	4.02	060	58559	•	A Hysteroscopy, lysis		91'9	ΝA	5.66	0.41	
58260		٧	Vaginal hysterectomy	14.02	NA	7.04	1.76	060	58560	٩	 A Hysteroscopy, resect septum 	t septum	66'9	Y.	2.98	0.46	
58262		4	Vag hyst including t/o	15.81	NA	1.7.1	1.98	060	19585	•	 A Hysteroscopy, remove myoma 	ve myoma	66.6	NA	4.13	9.65	
58263		٧	Vag hyst w/t/o & vag repair	17.10	NA	8.24	2.12	060	58562	•	 Hysteroscopy, remove fb 	ve fb	5.20	3.81	2.27	0.34	
58267		٧	Vag hyst w/urinary repair	18.23	ΝA	8.74	2,26	060	58563	•	_	lon	91.9	33.55	2.66	0.40	
58270		¥	Vag hyst w/enterocele repair	15.20	NA	7.32	1.90	060	58565	۹.	 A Hysteroscopy, sterilization 	ization	7.06	37.75	3.95	0.90	
58275		Ą	Hysterectomy/revise vagina	16.90	NA	8.22	2.08	060	58570	d	Tih, uterus 250 g or less	less	15.75	V.	7.96	<u>s</u> .	
58280		¥	Hysterectomy/revise vagina	18.20	NA	8.75	2.20	060	58571	•	Th w/t/o 250 g or less	228	17.56	Y :	8.85	1.56	
58285		Ą	Extensive hysterectomy	23.30	N.	10.36	1.13	060	58572	•		540	96'61	Ý.	9.49	2.55	
58290	,	4	Vag hyst complex	20.17	NA	9.30	2.53	060	58573	•	A Tih w/t/o uterus over 250 g	r 250 g	22.98	NA	10.98	5.09	
58291		Ą	Vag byst incl t/o, complex	21.96	NA	6.67	2.81	060	58578	_	Laparo proc, uterus		0.00	0.00	0.00	0.00	-
58292		4	Vag hyst to & repair, compl	23,25	NA	10.46	2.97	060	58579	_		fure	0.00	0.00	0.00	0.00	-
58293		¥	Vag hyst w/uro repair, compl	24.23	ΝA	10.84	3.10	060	28600	•		ı tube	5.86	NA	3,39	0.75	
58294		Ą	Vag hyst w/enterocele, compl	21.45	NA	71.6	2.74	060	28605	۹,		ı tıbe	5.25	ΝĄ	3.13	0.67	
58300		z	Insert intrauterine device	1.01	0.80	0.37	0.05	XXX	58611	٩		по-р	1.45	NA	0.55	60'0	• •
58301		¥	Remove intrauterine device	1.27	1.13	0.48	80.0	000	58615	4	 A Occlude fallopian tube(s) 	pe(s)	3.91	Ϋ́	2.28	0.26	
58321		٧	Artificial insemination	0.92	1.07	0.34	0.05	000	58660	•			11.54	NA	29.62	1.52	
58322		¥	Artificial insemination	1.10	1.06	0.42	0.07	000	58661	•	_	e adnexa	11.30	NA	5.16	0.77	
58323		٧	Sperm washing	0.23	0.16	60.0	0.02	000	58662	•		lesions	12.08	NA	5.91	1.50	
58340		K	Catheter for hysterography	88.0	2.00	09:0	90.0	000	58670	•		autery	5.86	N.A	3.43	0.75	
58345		٧	Reopen fallopian tube	4.67	NA	2.45	0.31	010	58671	**	 A Laparoscopy, tubal block 	olock	5.86	NA	3.41	97.0	
58346		Ą	Insert heyman uteri capsule	7.48	Ν	4.06	0.47	060	58672	4	_	oplasty	12.88	ΝĄ	6.20	1.65	
58350		٧	Reopen fallopian tube	1.03	1.33	0.92	0.07	010	58673	ď		gostomy	13.99	Y Z	6.51	62.1	
58353		٧	Endometr ablate, thermal	3.57	20.53	2.00	0.24	010	58679	0		t-ovary	0.00	0.00	0.00	0.00	
58356		¥	Endometrial cryoablation	6.36	18.91	2.52	0.42	010	58700	4	_	n tube	12.84	¥Z ;	6.83	08.7	
58400		¥	Suspension of uterus	7.06	NA	4.14	0.80	060	58720	٧.		ıbe(s)	12.08	Y.	67.9	4. 9	
58410		¥	Suspension of uterus	13.70	ΝA	6.82	1.75	060	58740	.		vary	14.79	ď;	64.4	68.1	
58520		V.	Repair of ruptured uterus	13.38	YZ ;	7.42	2.17	060	05785	•		3	15.50	K	7.30	66.0	
58540		∢ .	Revision of uterus	15.61	ď.	6.5	2.02	060	28/32		A Einstein (utx(s)	(s)	12.85	ζ <u>γ</u>	6.27	1 77	
58541		₹ <	Lsn, uterus 250 g or less	16.41	ć z	71.8	2.06	060	58770	. •	Create new fulbal opening	ening	14.69	Y.	7.11	88.	
26542		۲. ۵	I sh utenis above 250 a	16.74	Ϋ́	 	2.14	060	58800	. 4	Drainage of ovarian cyst(s)	cyst(s)	4.54	3.41	2.96	0.58	
58544		<	i.sh w/t/o uterus above 250 g	18.24	N A	8.87	2.33	060	58805	. •	Drainage of ovarian cyst(s)	cyst(s)	6.34	NA	4.62	1.03	
58545		₹	Laparoscopic myomectomy	15.45	NA	7,40	1.81	060	58820	٥,	Drain ovary abscess, open	, open	4.62	NA	3.22	0.59	
58546		¥	Laparo-myomectomy, complex	19.84	NA	9.00	2.54	060	58822	•4.	Drain ovary abscess, percut	, percut	11.71	NA	68.9	1.90	
58548		¥	Lap radical hyst	31.45	N.	14.92	2.20	060	58823	۷.	 Drain pelvic abscess, percul 	, percut	3.37	14.89	50.	0.28	
58550		Y	Laparo-asst vag hysterectomy	14.97	NA	7.50	1.88	060	58825	٧,	Transposition, ovary(s)	(s)	11.70	ΥN	6.02	.50	
58552		٧	Laparo-vag hyst incl t/o	16.78	ΝA	8.22	1.91	060	28900	٠.	Biopsy of ovary(s)		6.51	ΝA	4.68	1.05	
58553		Ą	Laparo-vag hyst, complex	19.96	ΝĀ	80.6	2.55	060	58920	4	 Partial removal of ovary(s) 	vary(s)	11.87	K.	0.00	1.52	
58554		٧	Laparo-vag hyst w/t/o, compl	22.98	NA	10.63	2.54	060	58925	•	 Removal of ovarian cyst(s) 	cyst(s)	12.33	NA N	6.47	50.1	
	'CPT co	des and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	lical Associa	tion, All Ri	ghts		1	CPT codes	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	copyright 2009 Ame	rican Medic	al Associatio	n. All Righ	2	
	Reserved.	d.	Reserved. If all the majority for ender not remake he Meditors misses note that these values have hear	on occupant	to that those	evalues have	2		∝	Reserved. 2 If values an	Reserved. Traines are reflected for codes not payable by Medicare, please note that these values have been	avable hy Medicare.	please note	that these va	lues have be	9	
	establish	ted as a c	stabilished as a courtesy to the general public and are not used for Medicare payment	ot used for Ma	edicare payn	nent.			υ,	stablished a	established as a courtesy to the general public and are not used for Medicare payment	public and are not u	sed for Med	icare payme	. T		
	The but	dget neu	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not refler reflected in	cted in the R	VUs for CPT		. 2	The budget odes 98940	'The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940 98941 and 98942. The remired reduction will only be reflected in the files used for	the chiropractic dem equired reduction wi	ionstration i	s not reflecte flected in th	d in the R VI e files used f	Us for CPT	
	Medicare	Medicare payment.	nt.	S fino III.					i 2.	Medicare payment	yment.		ì				
	4 Global	totals fo	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.					•	Global tota	Global totals for malpractice RVUs may not sum due to rounding	iay not sum due to ro	ounding.				

Reserved,

[Trigules are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 89940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice R VUs may not sum due to rounding.

	Global	000	000	000	000	000	MWIM	MIMIM	MIMIM	MOMIN	MMM	MIMIM	MIMIM	MBMIM	MIMIM	MDMIM	MMM	222	MIMIM	MOMOM	MIMIM	MOMOM	MMM	MIMIM	060	060	060	060	010	010	060	060	060	060	060	060	000	060	000	λλλ	λλλ	λλλ	010		
Mal-	RVUs 1.	0.17	0.53	0.53	0.22	1.08	5.59	2.78	3.19	0.37	0.35	1.27	2.20	0.44	6.54	3.43	3.90	1.86	6.16	3.28	3.62	6.94	3.82	4.30	0.95	1.02	1.08	1.42	09.0	1.22	0.32	1.29	0.44	1.39	1.69	0.50	0.21	1.40	0.46	0.00	0.00	0.00	0.12	nts	
Facility	RVUs ²³	0.30	1.20	1.22	1.80	1.87	16.34	5.19	6.52	0.80	0.62	2.37	4.21	0.93	18.33	6.17	7.99	3.27	17.12	5.81	6.82	18.97	92.9	69.8	5.69	3.70	3.49	3.93	5.04	3.05	3.34	3.71	5.08	3.59	3.99	4.48	08.1	4.76	1.12	0.00	0.00	0.00	86.1	on. All Righ	
Non- Facility	RVU6 ^{2,3}	0.94	2.24	NA	NA	NA	ΥZ	NA	NA	NA N	Ϋ́	4.70	19.8	1.27	NA	NA	NA	ΝA	AN	NA	NA	NA	NA	NA	3,34	4.23	4.07	NA	2.25	3.55	A'A	NA	N A	ΥN	ΝĄ	NA	NA	NA	NA	00.00	0.00	0.00	2.39	cal Associati	
Physi- cian	Work RVUs ^{2,3}	0.79	2.41	2.48	4.06	4.94	26.80	13.48	15.29	1.71	1.61	6.22	1.04	2.13	30.34	15.95	18.26	8.53	28.21	15.04	16.59	31.78	17.50	19.70	4.39	4.68	4.97	6.51	3.01	5.57	5.90	5.92	8.23	6.38	7.74	9.30	3.99	6.40	2.13	0.00	0.00	000	1.78	erican Medio	
	Description	Insert cervical dilator	Episiotomy or vaginal repair	Revision of cervix	Revision of cervix	Repair of uterus	Obstetrical care	Obstetrical care	Obstetrical care	Antepartum manipulation	Deliver placenta	Antepartum care only	Antepartum care only	Care after delivery	Cesarean delivery	Cesarean delivery only	Cesarean delivery	Remove uterus after cesarean	Vbac delivery	Vbac delivery only	Vbac care after delivery	Attempted vbac delivery	Attempted vbac delivery only	Attempted vbac after care	Treatment of miscarriage	Care of miscarriage	Treatment of miscarriage	Treat uterus infection	Abortion	Abortion	Abortion	Abortion	Abortion	Abortion	Abortion	Abortion	Abortion (mpr)	Evacuate mole of uterus	Remove cerclage suture	Fetal invas px w/us	Laparo proc, ob care/deliver	Maternity care procedure	Drain thyroid/tongue cyst	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	
	Status	A	4	Ą	Ą	٧	¥	Ą	¥	¥	Ą	4	٧	Ą	٧	ĸ	4	¥	٧	A	٧	Ą	∢	¥	4	V	٧	٧	œ	*	~	~	~	~	~	24	æ	¥	¥	O	ပ	O	¥	codes and	eđ.
	HCPCS Mod		59300	59320	59325	59350	59400	59409	59410	59412	59414	59425	59426	59430	59510	59514	59515	59525	59610	59612	59614	59618	59620	59622	59812	59820	59821	59830	59840	59841	59850	59851	59852	59855	59856	59857	29866	59870	59871	29897	86868	59899	00009	CPT	Reserved
	Giobal	060	060	060	060	060	060	060	060	060	060	060	000	000	000	YYY	000	000	000	000	000	000	000	000	000	000	000	XXX	XXX	000	000	000	000	060	060	060	060	060	060	060	060	060	010		
± Œ	Practice RVUs ^{2,3}	1.10	1.84	1.60	2.00	2.21	2.61	2.93	2.08	2.21	2.35	1.49	0.19	0.00	0.20	0.00	0.28	0.65	0.75	0.48	0.14	0.00	0.14	0.13	0.00	0.11	0.11	0.09	0.16	1.14	0.48	1.14	1.96	2.89	2.74	2.76	0.80	0.79	3.09	0.31	2.66	2.62	09.0	ights	
Facility	RVU8 ²³	4.86	9.37	9.27	11.37	12.94	15.74	16.93	11.12	12.58	13.86	7.98	1.63	00'0	1.74	0.00	99.0	1.36	1.48	10.1	1.04	0.79	0.25	0.63	0.43	0.20	0.73	0.34	0.28	2.29	3.63	2.46	3.75	6.78	6.52	6.47	7.34	7.22	66.9	3.83	6.30	5.97	1.42	tion, All R	
Non- Facility	RVUs ^{2,3}	NA	Y.V	NA NA	NA	NA NA	NA NA	NA	NA	NA	NA	NA	2.21	0.00	2.54	0.00	1.72	NA	NA	1.56	1.04	0.79	0.25	0.63	0.43	0.20	ΝA	NA	NA	4.68	NA	4.95	NA	NA	NA	NA	NA	NA	NA	NA	ΝA	NA	2,14	ical Associa	
Physi- cian	Work RVUs ^{2,3}	8.12	19.42	18.24	24.15	27.15	33.97	36.97	22.65	26.06	29.06	15.68	3.52	0.00	3.82	00.0	1.30	3.00	3,44	2.20	99'0	0.00	99.0	0.53	0.00	0.53	1.99	68'0	0.74	5.24	8.99	5.24	8.99	13.26	12.56	12.64	14.98	14.82	14.15	5.86	12,19	12.01	2.73	merican Med	
	Description	Removal of ovary(s)	Removal of ovary(s)	Resect ovarian malignancy	Resect ovarian malignancy	Resect ovarian malignancy	Tah, rad dissect for debulk	Tah rad debulk/lymph remove	Bso, omentectomy w/tah	Resect recurrent gyn mal	Resect recur gyn mal w/lym	Exploration of abdomen	Retrieval of oocyte	Transfer of embryo	Transfer of embryo	Genital surgery procedure	Amniocentesis, diagnostic	Amniocentesis, therapeutic	Fetal cord puncture, prenatal	Chorion biopsy	Fetal contract stress test	Fetal contract stress test	Fetal contract stress test	Fetal non-stress test	Fetal non-stress test	Fetal non-stress test	Fetal scalp blood sample	Fetal monitor w/report	Fetal monitor/interpret only	Transabdom amnioinfus w/us	Umbilical cord occlud w/us	Fetal fluid drainage w/us	Fetal shunt placement, w/us	Remove uterus lesion	Treat ectopic pregnancy	Treat ectopic pregnancy	D & c after delivery	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights							
	Status	4	: ∢	<	<	٧	٧	¥	4	K	<	4	٧	၁	∢	O	<	¥	<	٧	٧	¥	٧	¥	¥	¥	٧	٧	ď	A	∢	٧	¥	A	4	¥	٧	¥	٧	٧	∢	V	¥	codes and	ed.
	N																					1C	70		IC	56																		CPT	Reserved
	CPT"/	58940	58943	58950	58951	58952	58953	58954	58956	58957	58958	28960	58970	58974	58976	58999	59000	10065	59012	59015	59020	59020	59020	59025	59025	59025	59030	59050	15065	59070	59072	59074	92069	59100	59120	59121	59130	59135	59136	59140	59150	15165	59160		

Reserved.

I values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

(Triguless are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neurality reduction from the chropractic demonstration is not reflected in the R VUs for CPT codes 19840, 18941, and 198942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice R VUs may not sum due to rounding.

	Giobal	260	060	060	000	060	060	060	060	060	060	060	060	060	222	060	060	060	060	060	060	060	060	060	060	000	060	060	060	9 8	26	260	060	060	060	060	060	060	777	060	060	060						
Mal- Practice	RVUs***	3.65	4.57	4.72	1.52	1.55	3.10	1.31	6.11	7.75	8.13	7.56	86.9	8.03	0.37	7.28	8.27	9.14	9.24	6.84	7.75	1.52	5.30	5.44	8.53	7.91	7.76	7.50	7.76	8.19	84.7	737	4.38	3.55	8.28	10.01	7.31	7.19	0.37	10.76	11.69	13.77	phts	l de		VUs for CPT i for		
Facility PE	RVUs.	40.6	12.46	11.40	2.71	96.5	8.70	81.8	14.85	18.03	18.16	18.00	16.64	18.41	0.65	16.85	18.92	20.87	20.24	17.53	17.48	19.63	13.26	13.50	19.25	18.13	17.86	16.95	17.77	18.60	76.01	16.73	12.85	11.56	16.61	22.10	17.05	16.40	0.64	24.24	24.97	31.53	tion, All Rig	values have	nent.	cted in the R'		
Non- Facility PE	RVUs ²³	Ϋ́	Ϋ́Z	ΥN	ΝA	NA	Ϋ́Z	ΥN	Y.	ΥZ	Ϋ́Z	Y Z	NA	Ϋ́	NA	Ϋ́	Ϋ́	ΥN	Y Y	Ϋ́	Z Z	Ϋ́	Υ V	Ϋ́	Ϋ́	Ϋ́	V.	Y.	Ϋ́,	Y ;	e s	K X	ς γ	Ž	×	NA A	Y V	Ϋ́	N.A	Y.	ΝA	Ϋ́	dical Associa	ore that these	fedicare payr	a is not reflec reflected in		
Physi- clan Work	RVUs ^{2,3}	13.41	16.92	17.37	5.83	5.77	11.41	13.41	23.31	28.51	30.07	27.94	25.77	29.52	1.39	27.32	30.40	34.08	34.93	25.17	28.50	29.17	19.50	20.01	31.73	29,10	28.53	27.59	28.71	30.11	27.52	21.93	21.12	16.22	30.63	36.99	27.10	26.45	1.38	39.69	43.28	56.89	American Me	are, please no	not used for N	demonstrations will only be		to rounding.
	Description	Pierce skull for drainage	Pierce skull & remove clot	Pierce skull for drainage	Pierce skull, implant device	Insert brain-fluid device	Pierce skull & explore	Pierce skull & explore	Open skull for exploration	Open skull for exploration	Open skull for drainage	implt cran bone flap to abdo	Open skull for drainage	Open skull for drainage	Decompressive craniotomy	Decompressive lobectomy	Decompress eye socket	Explore/biopsy eye socket	Explore orbit/remove lesion	Explore orbit/remove object	Subtemporal decompression	Incise skull (press relief)	Relieve cranial pressure	Incise skull for surgery	Incise skull for surgery	Incise skull for brain wound	incise skull for surgery	Incise skull for surgery	Incise skull for surgery	Memory of shall lesion	Remove infected skull bone	Removal of brain lesion	Remove brain lining lesion	Removal of brain abscess	Removal of brain lesion	Implt brain chemotx add-on	Removal of brain lesion	Remove brain lining lesion	Removal of brain lesion	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. 7 Faques are reflected for codes not navable by Medicare-nlease note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	" The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940. 98941, and 98942. The required reduction will only be reflected in the files used for	at.	Global totals for malpractice KVUs may not sum due to rounding			
	Status	<	¥	∢	<	٧	¥	4	4	4	٧	٧	4	٧	4	V	∢	¥	V	٧	٧	٧	٧	4	٧	∢	٧	٧	∢ .	∢ .	∢ •	< <	۲ -	: <	٠ ح	4	Ą	¥	<	٧	¥	٧	odes and	ed.	hed as a c	ndget neu 8940, 989	Medicare payment	i totals for
	₽o₩																																										CPT (Reserved.	establis	The b	Medica	Clobs
CPT ^{4.3} /	HCPCS	61153	61154	61156	61210	61215	61250	61253	61304	61305	61312	61313	61314	61315	61316	61320	61321	61322	61323	61330	61332	61333	61334	61340	61343	61345	61440	61450	61458	61460	61470	01480	06+10	61501	61510	61512	61514	91519	61517	61518	61519	61520						
	34 Global					060																						060		•	000											060				CPT		
Mai	RVUs.	0.12	1.29	1.55	2.3(1.62	1.99	2.23	2.67	3.4	2.36	3.29	2.2	0.63	0.8	0.08	2.4	3.14	3.2	0.59	2.62	3.44	4.1	2.28	2.7	3.95	3.11	2.80	0.0	0.0	0.1	0.41	0.30	0.13	0.20	0.14	1.47	1.31	3.09	2.59	4.58	5.11	Rights	, Per	1000	RVUs for sed for		
Facility	RVUs.23	0.50	6.84	6.77	9.29	7.38	8.93	8.61	11.80	14.99	68.6	11.80	9.57	5.36	6.65	0.31	9.14	11.31	12.46	1.76	8.89	9.26	11.06	8.74	9.91	10.79	18.65	9.52	0.00	0.00	1.33	2.02	77	× ×	1.33	1,20	5.22	2.33	9.47	7.82	12.02	12.59	Association. All Rights	e eralinecha	ment.	ected in the		
Non- Facility PE	RVUs ^{2,3}	1.25	NA	NA	NA	NA	N A	NA	ΝA	NA	AN	NA	NA	NA	NA	1.84	Z V	NA	NA	NA	NA	ΝA	NA	NA	NA	NA	NA	ΝĀ	0.00	0.00	Y Z	Ϋ́,	K 4	Y A	. Y	Ϋ́	Y.	NA	NA	NA	NA NA	NA	lical Assoc	to that thee	edicare pay	is not reflected in		
Physi- cian Work	RVUs ^{2,3}	1.56	16'6	11.15	16.32	12.29	14.67	16.18	21.88	28.29	18.18	23.07	17.54	6.05	8.71	76.0	16.69	21.01	22.91	4.44	17.07	19.11	23,37	17.91	20.82	24.99	31.86	20.63	0.00	0.00	. 58	(4)	5 5	5.1	2.10	0.89	5.40	4.99	11.51	9.52	17.10	18.80	American Mec	Or cools can	ate, prease no ot used for M	demonstration n will only he		to rounding.
	Mod Status Description	A Biopsy of thyroid	A Remove thyroid lesion	A Partial thyroid excision	A Partial thyroid excision	A Partial removal of thyroid	A Partial removal of thyroid	A Removal of thyroid	A Removal of thyroid							A Aspir/inj thyroid cyst	 A Explore parathyroid glands 		A Explore parathyroid glands	A Autotransplant parathyroid	A Removal of thymus gland	A Removal of thymus gland	A Removal of thymus gland	A Explore adrenal gland	 A Explore adrenal gland 		 A Remove carotid body lesion 	 A Laparoscopy adrenalectomy 		 Endocrine surgery procedure 			A Kemove brain cavity finid	A Demove brain canal fluid		A Brain canal shunt procedure	A Twist drill hole						CPT codes and descriptions only are copyright 2009 American Medical	Reserved.	It values are reflected for codes not payable by incurrency prease note that mest variates table as a courtesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT modes 08040, 08043, and 08047. The remitted reduction will only be reflected in the files used for	Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding
CPT ¹³ /	HCPCS	00109	60200	60210	60212	60220	60225	60240	60252	60254	60260	60270	60271	60280	60281	60300	00509	60502	90509	60512	60520	60521	60522	60540	60545	00909	90909	05909	6909	66909	00019	61001	07019	07010	95019	61070	61105	61107	90119	61120	61140	61150			ų.	,	, pr. 1	•
		•	_	_	_	_	-	_	_	_	_	_	_	_	_	-	-	_	-	-	-	-	-	_		-	-	-								-	-	-	_	_		-						

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The first large are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CP T codes 95940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R VUs may not sum due to rounding.

_	060			060	060						060									000	000	e XX	XXX	000	777	060							060	060	260	060			747	
Mai- Practice	-		10.74	5.31	3.83	06.6	4.62	7.67	3.63	10.40	11.10	0.64	1.59	0.40								2.67						11.28						_		10.32	Rights	ve been	RVUs for (
Facility PE	31.01	31.12	31.24	25.41	25.52	29.66	23.98	25,15	24.18	28.99	27.02	4.64	13.91	2.70	•	31.40	12.23	12.34	13.71	3.76	7.14	9.12	9.87	4.50	3.16	19.95	33.40	24.35	10.03	30.31	34.47	37.85	28.76	33.35	17.70	22.29	sation. Au	se values hav	lected in the in the in the files u	
Non- Facility PE	N AN	VZ.	NA A	NA	Y Z	K Z	Z	NA	NA	Y Z	Y Z	ć K	NA	N A	NA	YZ;	K Z	Z Z	NA	NA	Y Z	K Z	ΝΑ	Y X	Z Z	NA	NA V	Z Z	ξ 4	Y V	NA	NA	Y Y	₹ ź	K :	Y ;	edical Assoc	tote that thes	on is not reflected	
Physical cian Work	46.87	46.87	42.98	33.57	39,31	36.13	29.84	31.04	32.40	41.94	40.82	88.6	29.63	7.41	27.84	44.94	35.03	18.58	22.01	6.95	20.12	16.60	24.28	12.32	8.66	32.40	63.31	41.49	21.18	54.43	63.22	69.45	50.44	59.86	18.70	37.97	09 American M	edicare, please n	etic demonstration retion will only b	due to rounding
	Infratemporal approach/skull	Infratemporal approach/skull	Orbitocranial approach/skull	Transtemporal approach/skull	Transcochlear approach/skull	Transferroral approach/shull	Resect/excise cranial lesion	Resect/excise cranial lesion	Resect/excise cranial lesion	Resect/excise cranial lesion	Resect/excise cranial lesion	Transect artery sinus	Transect artery, sinus	Transect artery, sinus	Transect artery, sinus	Remove aneurysm, sinus	Resect/excise lesion, skull Resect/excise lesion, skull	Repair dura	Repair dura	Endovase tempory vessel ocel	Transcath occlusion, ens	I ranscath occlusion, non-cus Intracranial angionlasty	Intracran angiopisty w/stent	Dilate ic vasospasm, init	Dilate ic vasospasm add-on	Intracranial vessel surgery	Brain aneurysm repr, complx	Bram ancurysm repr, complx	Brain aneurysm repr, simple	Inner skull vessel surgery	Clamp neck artery	Revise circulation to head	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	reserved. Ya Natues are reflected for codes not payable by Medicare, please note that these values have been scabilished as a contest to the nancel millio and are not used for Medicare naturent	* Shadousheva as countesy to use gustran prous. and as not so to in recurse for systems, the budgest enaturality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment. Global totals for malpractice R VUs may not sum due to rounding.				
į		¥	Ą	Ą	∢ •	∢ ⊲	< <	: ∢	٧	¥ ·	∢ -	< <	· 4	¥	4	∢ .	< ∢	< ∢	¥	٧	∢.	< ∞	~	z	zz	<	¥	∢ •	< 4	< <	٧	Y	¥	∢•	۷ ٠	≺ .	codes and c	veu. dues are refli irhed as a co	budget neuti 98940, 9894	Medicare payment Global totals for
f _{€1} 1dD		16519	61592	61595	61596	76519	61600	10919	61605	90919	61607	61609	01919	11919	61612	61613	61618	61618	61919	61623	61624	61626	61635	61640	61642	08919	61682	61684	01080	61692	61697	86919	90219	61702	61703	61705	IJD.	Keserved ² If values	The codes	Medic 4 Glob
140	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060		,		
Mai- Practice	12.73	8.54	8.09	14.65	12.35	4,43	6.22	3.55	10.22	9.82	10.70	8 51	8.38	868	8,48	1.46	0.06	5.04	0.83	1.09	6.53	6.30	18.1	7.71	8.79	10.02	7.17	7.69	9.90	4.27	3.79	9.50	06.6	9,49	45.1	7.42	ghts	been	VUs for CP1 d for	
Facility PE	26.86	19.21	18.44	28.27	25.80	70.71	15.21	2																														ē	~ e	
Non- Facility PE								2	22.11	20.58	22.47	10.20	18.93	19.84	19,10			14.12				15.74	15.02	17,53	19.72	22.48	16.85	17.75	35.79	27.53	31.38	36.42	29.45	28.82	33.03	30.04	tion. All Ri	values har	near. Sted in the the files t	
¥ 8	NA NA	NA	NA	NA	NA ;										19,10	16.80	20.44	14.12	11.98	9.53	15.49	NA 15.74 NA 17.11							•							NA 30.04	lical Association. All Rights	te that these values har	curcate payment. a is not reflected in the reflected in the	
Physi- No							AN AN	VA	NA	NA	AN S		NA	NA	NA 19.10	NA 16.80	20.44	NA 14.12	NA 11.98	NA 9.53	NA 15.49		Ϋ́N	A ?		ΝΑ	NA	¥.	•	V V	NA	NA	NA	NA	Y ;	27.28 NA 30.04	American Medical Association. All Ri	icare, please note that these values ha	to use use to mention payment, c demonstration is not reflected in the ion will only be reflected in the files to	e to rounding.
Physician Clan Work		31.41	29.76	53.90	45.43	10.28 NA 21.36 NA	AN AN	13.05 NA	37.59 NA	36.35 NA	39.35 NA	Z Z	30.81 NA	33.03 NA	NA 19.10	sion 27.26 NA 16.80	NA 27,44	23.27 NA 14.12	15.44 NA 11.98	NA 9.53	24.00 NA 15.49	K Z	33.82 NA	28.35 NA	K K	36.84 NA	26.38 NA	28.29 NA	Y Z	34.34 NA	38.88 NA	34.93 NA	38.41 NA	37.61 NA	all 42.46 NA	Resect nasopharynx, skull 27.28 NA 30.04	descriptions only are copyright 2009 American Medical Association. All Ri	lected for codes not payable by Medicare, please note that these values have	ou neesy to use general public and are not used to inventioned payment, trailly reduction from the chiropractic demonstration is not reflected in the 41, and 89942. The required reduction will only be reflected in the Files to	nt. • malpractice RVUs may not sum due to rounding.
Physical Color Color (Work Work & Color & Colo	46.84	31.41	29.76	53.90	Removal of brain lesion 45.43	Implant brain electrodes 10.28 NA	21.30 INS 22.88 NA	Remove brain electrodes 13.05 NA	Removal of brain lesion 37.59 NA	Removal of brain tissue 36.35 NA	Removal of brain tissue 39.35 NA	34.15 NA 31.30 NA	Incision of brain tissue 30.81 NA	Removal of brain tissue 33.03 NA	Removal of brain tissue 31.18 NA 19.10	27,26 NA 16.80	Excision of brain tumor 46.23 NA 27.44 Democral of printing and 13.3.3 NA 20.10	Removal of printiary gland 23.27 NA 14.12	Retease of skull seams 15.44 NA 11.98	Release of skull seams 20.27 NA 9.53	Incise skull/sutures 24.00 NA 15.49	23.16 NA 26.15 NA	Excision of skull/sutures 33.82 NA	Excision of skull tumor 28.35 NA	34.59 NA 32.32 NA	36.84 NA	26.38 NA	28.29 NA	50.43 NA	34.34 NA	38.88 NA	34.93 NA	38.41 NA	Orbitocranial approach/skull 37.61 NA	Orbitocranial approach/skull 42.46 NA	A Resect nasopharynx, skull 27.28 NA 30.04	les and descriptions only are copyright 2009 American Medical	Reserved. The lates are reflected for codes not payable by Medicare, please note that these values have been an effected for codes and the control card in the card in th	satabilistica as a countesy to the general photo and are not used not instance plynicut. * The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VU3 for CPT codes 989401, and 98942. The required reduction will only be reflected in the files used for	Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.

Global	060	060	222	ZZZ	060	080	060	060	060	060	010	060	060	060	060	060	XXX	XX	XX	060	010	010	000	9 8	000	000	000	010	010	000	060	9	8 8	260	960			
Mal- Practice RVUs ^{2,3,4}	5.43	65.5	0.54	080	5.74	4.46	7.96	4.92	6.10	3.28	1.54	5.22	4.30	3.66	3.64	2.98	0.18	00'0	0.18	4.17	0.40	0.28	0.23	0.35	0.11	0.19	0.15	0.39	0.20	0.13	0.63	0.23	0.21	6.00	0.92	gats been	VUs for CPT 1 for	
Facility PE RVUs ^{2,3}	12.59	13.33	0.94	04.1	14.14	11.94	19.09	14.48	14.58	9.33	5.16	12.68	11.96	9.72	10.70	8.29	ΑN	Y Z	0.35	10.69	4.17	2.08	1.50	1.92	0.60	0.71	0.84	94.1	1.46	19.0	5.29	1.56	1.52	07.4	5.52	ion. All Kij alues have	ent. ted in the R' he files used	
Non- Facility PE RVUs ^{2, 3}	X X	C Z	N A	N.A.	e z	Z Z	NA A	Ϋ́	ď :	₹ ₹ Z Z	Y Z	NA A	NA	X	K Z	Z Z	1.82	1.47	0.35	K Z	12.41	6.77	4.24	5.5	2.46	3.54	2.25	5.35	5.02	3.59	N.	5.59	5.32	ď;	ď.	ical Associai e that these v	dicare paym is not reflect reflected in t	
Physi- cian Work RVUs ^{2,3}	19,99	20.47	2.00	3.00	21.10	16.40	29.27	23.10	22.45	12.07	5.68	19.19	15.89	14.00	13.90	11.35	0.74	0.00	0.74	15.54	6.04	4.42	3.00	5.73	1.37	1.35	2.15	2.63	2.33	1.54	8.88	3.00	2.91	9.14	12.77	nerican Med re, please not	t used for Me emonstration will only be	rounding.
Description	Repair of skull & brain	Repair of shull with graft	Retr bone flap to fix skull	Neuroendoscopy add-on	Dissect brain w/scope	Neuroendoscopy w/fb removal	Remove brain tumor w/scope	Remove pituit tumor w/scope	Establish brain cavity shunt	Establish brain cavity shunt Establish brain cavity shunt	Replace/irrigate catheter	Establish brain cavity shunt	Brain cavity shunt w/scope	Establish brain cavity shunt	Establish brain cavity shunt	Replace/revise brain shunt	Csf shunt reprogram	Csf shunt reprogram	Csf shunt reprogram	Remove train cavity sount Renisce brain cavity chunt	Epidural lysis mult sessions	Epidural lysis on single day	Interdiscal perq aspir, dx	Urain spinal cord cyst Needle bioney cninal cord	Spinal fluid tap, diagnostic	Drain cerebro spinal fluid	Inject epidural patch	Treat spinal cord lesion	Treat spinal canal lesion	Injection for myelogram	Percutaneous diskectomy	Inject for spine disk x-ray	Inject for spine disk x-ray	Injection into disk lesion	Injection into spinal artery	cert of codes and descriptions only are copyright 2009 American Medical Association. All Rights to the control of the codes not payable by Medicare, please note that these values have been If values are reflected for codes not payable by Medicare, please note that these values have been	isstablished as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Maddone and the files used for the files used for the files of the files	Global totals for majpractice RVUs may not sum due to rounding.
Status	۷٠	< ⊲	: ∢	¥	< <	< <	٧	<	∢ ·	< 4	< ≺	Ą	¥	٧	∢ <	< ∢	٧	¥	∢ ∢	₹∢	< ∢	¥	∢ .	< ∢	< <	4	¥	∢ •	< <	∢	4	A	∢ .	€ .	∢ .	codes and ed. ues are ref	Established as a cor The budget neutra codes 98940, 9894	al totals for
N																		IC	56																1	Reserved	The b	Glob.
CPT ^{1,3} HCPCS	62145	62147	62148	62160	62161	62163	62164	62165	62180	62190	62194	62200	62201	62220	62223	62230	62252	62252	62252	05770	62263	62264	62267	89779	62270	62272	62273	62280	62282	62284	62287	62290	62291	76779	62294			
٠.	060											060	727	277	060	060	277	060	777	060	060	060	060		060			060	060	060	060	060	060	060	060		CPT	
Mal- Practice RVUs ^{2 A}	2.31	10.3	4.76	6.04	5.34	6.05	6.17	3.10	6	4 -												_															į.	
Facility PE XVUs ²³									κή ·	0.7	80	2.71	1.18	0.55	3.61	5.58	1.22	8.93	2.12	24.4	1.85	1.90	2.61	1.73	4.77	5.7	5.63	1.22	2.76	2.38	6.23	3.54	4.01	5.05	3.75	rignts e been	RVUs sed for	
u. že	15.83	21.85	11.89	14.57	12.82	14.29	13.99			1.88 0.7					9.49 3.61													10.81 1.22							10.09 3.75	anon. All Kignts e values have been	ment. ected in the RVUs I a the files used for	
Non- Facility F PE RVUs ^{2,3} R					NA 12.82		13.99	8.78	10.11		1.56	7.68	2.15	1.26		14.20	2.11	19.98	3.72		6.36	8.26	9.78	3.93		14.14	14.51		15.49	19.27	19.84		10.89	8.90	NA 10.09 3.75	cucat Association. All Kights ote that these values have been	tedicare payment. in is not reflected in the RVUs e reflected in the files used for	
Non- Facility PE PE		Z Z	Z V	NA		Z Z	NA 13.99	NA 8.78	NA 10.11	2.88	NA 1.56	NA 7.68	2.15	NA 1.26	9,49	NA 14.20	NA 2.11	NA 19.98	NA 3.72	7 66	NA 6.36	NA 8.26	NA 9.78	3.93	NA 11.90	NA 14,14	NA 14.51	NA 10.81	15.49	NA 19.27	NA 19.84	NA 9.97	NA 10.89	NA 8.90	14.05 NA 10.09 3.75	enerican medical Association. All Kights uc, please note that these values have been	ot used for Medicare payment. demonstration is not reflected in the RVUs in will only be reflected in the files used for	o rounding.
Physi- Non- cian Facility Work P.E. Status Description RVUs ²⁻² RVUs ²⁻² F	Revise circulation to head 37.07 NA	Z Z	Incise skull/brain surgery 17.52 NA	Incise skull/brain surgery 22.22 NA	19.73 NA	Implant brain electrodes 22.24 NA	Incise skull for treatment 23.09 NA 13.99	Treat trigeminal nerve 11.50 NA 8.78	Treat trigeninal tract 15.31 NA 10.11	Brain surgery using computer 4.03 NA 1.88	3.48 NA 1.56	Srs, cranial lesion complex 10.79 NA 7.68	Srs, cran les complex, addl 4.81 NA 2.15	Apply srs headframe add-on 2.25 NA 1.26	13.26 NA 9.49	Implant neuroelectrode 20.56 NA 14.20	Implant neuroelectrde, addl 4,49 NA 2.11	Implant neuroelectrode 32.88 NA 19.98	ddÆ! 7.91 NA 3.72	implant neuroelectrodes (0.24 NA 11.10	Revise/remove neuroelectrode 6.87 NA 6.36	7.37 NA 8.26	Implant neurostim arrays 9.73 NA 9.78	NA 3.93	Treat skull fracture 17.53 NA 11.90	Treatment of bead injury 21.30 NA 14.14	e 23.40 NA 14.51	Reduction of skull defect 22.71 NA 10.81	NA 15.49	24.39 NA 19.27	Incise skull repair 22.93 NA 19.84	14.45 NA 9.97	Repair of skull defect 15.97 NA 10.89	Kemove skull plate/thap	A Replace skull plate/flap 14.05 NA 10.09 3.75	1 codes and descriptions only are copyright JUDF American Medical Association. All Kights erved. erved. erved consistent of the codes not payable by Medicare, please note that these values have been	blished as a courtesy to the general public and are not used for Medicare payment. e budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs. \$89401, 98941, and 98942. The required reduction will only be reflected in the files used for	ander payment. obal totals for malpractice RVUs may not sum due to rounding.
Physi- Non- cian Facility I Work PE Description RVUs ^{2,2} R	A Revise circulation to head 37.07 NA	Euclon of chall attendes 38.10 NA	A Incise skult/brain surgery 17.52 NA	A Incise skult/brain surgery 22.22 NA	Incise skull/brain biopsy 19.73 NA	A Implant brain electrodes 22.24 NA	A Incise skull for treatment 23.09 NA 13.99	A Treat trigeminal nerve 11.50 NA 8.78	A Treat trigeninal tract 15.31 NA 10.11	Brain surgery using computer 4.03 NA 1.88	A Srs, cran les simple, add 3.48 NA 1.56	A Srs, cranial lesion complex 10.79 NA 7.68	Srs, cran les complex, addl 4.81 NA 2.15	A Apply srs beadframe add-on 2.25 NA 1.26	Implant neuroelectrodes 13.26 NA 9.49	A Implant neuroelectrode 20.10 NA 14.20	A implant neuroelectrde, addl 4,49 NA 2.11	A Implant neuroelectrode 32.88 NA 19.98	A implant neuroelectrde, addÆi 7.91 NA 3.72	implant neuroelectrodes (0.24 NA 11.10	A Revise/remove neuroelectrode 6.87 NA 6.36	A Institredo neurostim 1 array 7.37 NA 8.26	A Implant neurostim arrays 9.73 NA 9.78	Revise/remove neuroreceiver 5.20 NA 3.93 Treat claff facture 13.83 NA 10.03	A Treat skull fracture 17.53 NA 11.90	A Treatment of bead injury 21.30 NA 14.14	A Repair brain fluid leakage 23.40 NA 14.51	A Reduction of skull defect 22.71 NA 10.81	Reduction of skull defect 28.26 NA 15.19	A Repair skull cavity lesion 24.39 NA 19.27	A Incise skull repair 22.93 NA 19.84	Repair of skull defect 14.45 NA 9.97	A Repair of skull defect 15.97 NA 10.89	A Remove skull plate/flap 11.73 NA 8.90	62143 A Reptace skull plate/flap 14.05 NA 10.09 3.73	CPT codes and descriptions only are copyright 2009 American Medical Association. All Klights Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT costs 99940, 99941, and 98942. The required reduction will only be reflected in the files used for a solution of the second payment.	Accuracy posturation of the properties of the pr

Reserved.

The values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesty to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 98940, 98041, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R VUs may not sum due to rounding.

G eto	777	060	222	060	222	060	222	060	222	060	060	777	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	260	060	000	060	060	060	060	060	060	060	060						
Mal- Practice	0.57	5.92	86.0	5.94	99.0	7.30	0.79	5.42	0.51	8.02	6,45	160	9.00	4.99	6.57	5.55	6.17	4.45	3.25	2.81	2.14	5.86	1.35	15.9	1.59	1.68	5.70	11.89	12.10	12.09	0,11	4 C	5.41	8.07	7.95	7.19	7.16	6.63	6.55	5.25	86.3	phts	Loon	, , , , , , , , , , , , , , , , , , ,	/Us for CPT		
Facility PE PVIIs ^{2,3}	1.57	16.26	2.09	16.69	1.48	20.84	2.06	17.76	1.43	21.05	20.81	2.31	14.79	12.77	15.78	10.44	15.08	11.97	12.63	13.94	12.97	14.07	11.22	15.67	13.10	13.67	14.18	25.00	25.75	25.75	15.30	13.70	13.80	18.40	18.32	17.13	16.83	16,33	16.16	14.51	14.79	tion. All Rig	vahjec have)	raines nave (ted in the R	ine mes aser	
Non- Facility PE PUI 1023	Y X	VA	ΥZ	ΝΑ	NA	ΥN	NA V	ΥZ	ΥZ	Ϋ́	ΝΑ	Ϋ́	NA	ΥN	ΥZ	NA	NA	ΥA	Y Y	NA	Ϋ́	NA	NA	NA	ΝΑ	Ϋ́	NA	Y.	K Z	¥.	ď ž	ť <	(A	ž	AN	Ϋ́	Z.	ΥZ	NA	K Z	ΥZ	dical Associa	or that thece	fedicare payur	n is not reflec	icircica m	
Physi- ctan Work	3.28	25.97	4.36	29.34	3.19	37.38	4.32	30.78	3.03	33,92	33.92	4.82	22.08	99'61	24.18	20.40	22.69	16.36	18.76	18.79	21.97	21.54	25.14	23.95	29.75	31.32	21.31	43.73	44.49	44.48	25.69	10.13	10.80	29.67	29.79	27.37	26.34	25.73	25.56	22.26	21.99	Атепсап Ме	one of page no	not used for N	demonstratio	AL WILL OLLY O	to rounding.
Dannerishian	Spine disk surgery, thorax	Removal of vertebral body	Remove vertebral body add-on	Removal of vertebral body	Remove vertebral body add-on	Removal of vertebral body	Remove vertebral body add-on	Removal of vertebral body	Remove vertebral body add-on	Removal of vertebral body	Removal of vertebral body	Remove vertebral body add-on	Incise spinal cord tract(s)	Drainage of spinal cyst	Drainage of spinal cyst	Revise spinal cord ligaments	Revise spinal cord ligaments	Incise spinal column/nerves	Incise spinal column/nerves	Incise spinal column/nerves	Incise spinal column & cord	Release of spinal cord	Revise spinal cord vessels	Revise spinal cord vessels	Revise spinal cord vessels	Excise intraspinal lesion	Excise intraspinal teston	Excise intractinal lacion	Excise intraspinal lesion	Excise intraspinal lesion	Excise intraspinal lesion	Excise intraspinal lesion	Biopsy/excise spinal tumor	Biopsy/excise spinal tumor	Biopsy/excise spinal tumor	Biopsy/excise spinal tumor	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. * If values are reflected for codes not navable by Medicare, please note that these values have been	is values are reflected for events for payable by withteaut, please note that the established as a courtesy to the general public and are not used for Medicare payment	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	1), and 20212. The required reducine	Global totals for malpractice RVUs may not sum due to rounding					
į	* ×	٧	K	٧	¥	Y	4	¥	*	٧	4	Y	٧	٧	¥	¥	٧	¥	٧	V	٧	<	Ą	∢	¥	V	∢	∢ -	∢ .	∢ .	< <	< <	< ⊲	< <	₹	∢	٧	¥	A	Y	٧	codes and	ed. nec are refl	shed as a co	udget neut	Medicare payment	ıl totals for
CPT ^{1.3}		18069	63082	63085	63086	63087	63088	63090	63091	10159	63102	63103	63170	63172	63173	63180	63182	63185	63190	63191	63194	63195	961199	63197	63198	63169	63200	63250	63251	63252	69759	00750	19250	63270	63271	63272	63273	63275	63276	63277	63278	CPT	Reserved.	establis	The b	Medica	⁴ Globs
- Cichai	000	000	000	000	010	060	010	010	010	010	010	XXX	XXX	060	060	060	060	060	060	060	060	060	060	222	060	060	777	777	060	060	080	777	060	060	060	222	060	222	060	222	060				F.		
Mai- Practice	0.12	0.10	0.12	0.12	0.93	2.54	0.64	0.72	98'0	1.06	0.77	0.03	0.05	4.28	4.24	3.82	3.02	3.84	5.27	5.04	4.20	3.82	2.91	0.67	4.74	3.91	0.00	0.00	4.30	3.87	3.50	5.05	5.43	5.79	4.69	1.14	5.98	0.49	4.61	0.93	4.44	ghts	neod	1	VUs for CF	5	
Facility PE PVII.623	96.0	0.79	0.63	99.0	2.15	9.43	3,38	3.47	4.22	4.29	3.67	0.20	0.31	11.57	11.65	11.77	10.88	11.57	14.01	14.06	12.25	11.67	10.13	1.52	13.23	12.74	0.00	0.00	12.20	11.77	G 5	1.07	15.85	14.89	13.84	2.53	16.06	09.1	13,11	1.93	13.67	tion. All Ri	ayed saldey	values nave nent.	ted in the R	ure mea ase	
Non- Facility PE	4.28	3.64	3.98	3.77	NA	NA	Y V	ΝA	Y V	N.A	NA	0.62	98.0	ΝA	NA	N.	NA	ΝA	NA	NA	NA	NA	NA	Z,	NA	Ν	NA	Y.	Y.	Y.	Y Z	V V	V V	Y V	NA	NA	ΝĄ	NA	ΝA	Ϋ́	NA	cal Associa	a that these	dicare payn	is not reflect	בווכרוכת ייו	
Physi- cfan Work	16:1	1.54	2.04	1.87	1.29	11.54	4.30	4.28	9,60	6.05	4.60	0.48	0.75	17.51	17.64	16.28	15.78	16.72	20.70	21.90	17.18	16.05	13.03	3.15	20.18	18.61	0.00	0.00	17.82	17.12	15.22	3.47	25.36	23.42	21.73	5.25	26.09	3.26	19.47	4.04	22.75	merican Medi	are please not	ot used for Me	demonstration	will out y oc	o rounding.
Status Baserinding	A Inject spine	A Inject spine Vs (cd)	A Inject spine w/cath, c/t	A Inject spine w/cath Vs (cd)		 A Implant spinal canal cath 	 A Remove spinal canal catheter 	A Insert spine infusion device	A Implant spine infusion pump	A Implant spine infusion pump	A Remove spine infusion device	A Analyze spine infusion pump		 A Removal of spinal lamina 	 A Removal of spinal lamina 	 A Removal of spinal lamina 	A Removal of spinal lamina		A Removal of spinal lamina	 A Removal of spinal lamina 			A Low back disk surgery				_					A Common lamina add-on	A Colominos later submediate			_	A Decompress spinal cord		 A Neck spine disk surgery 	 A Neck spine disk surgery 	 A Spine disk surgery, thorax 	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. ? If values are reflected for codes not navable by Medicare release note that these values have been	it values are refrenced for cours not payable by incubate, prease note that mest value established as a courtest to the general public and are not used for Medicare payment.	3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding
- 9 - 9	,				_			_														_											_									CP1	Reserved.	estab	The	Medic	⁴ Glo
CPT ^{1,3} /	62310	62311	62318	62319	62350	62351	62355	62360	62361	62362	62365	62367	62368	63001	63003	63005	63011	63012	63015	63016	63017	63020	63030	63035	63040	63042	63043	6304	63045	63046	63047	63048	63051	63055	63056	63057	63064	63066	63075	63076	63077						

Global Gl

Mal- Practice	0.09	0.25	0.07	60:0	60.0	0.11	60.0	0.08	60.0	0.15	0.14	0.11	0.10	60.0	0.12	60.0	0.10	0.11	80.0	90.0	0.13	60:0	0.10	0.07	0.18	0.18	0.12	60:0	0.07	0.18	0.07	0.13	80:0	0.10	10.0	0.20	0.16	0.13	0.50	0.11	1.82	0.35	bts
Facility PE RVIIA ²³	96:0	99.0	0.79	99.0	0.41	0.30	0.41	89.0	0,63	0.79	0.79	99.0	0.70	0.64	0.33	0.25	0.27	0.37	0.55	0.27	1.04	0.56	98.0	0.39	1,23	0.65	=	0.56	0.81	98.0	0.72	1.17	0.82	0.90	0.07	1.78	1.43	1.51	3.22	1.53	6.33	3.21	tion. All Rig
Non- Facility PE PVIIs ^{2,3}	1.77	2.42	2.90	1.64	1.76	NA	1.77	2.28	3.07	4.58	1.74	1.94	1.93	1.95	NA	ΝA	NA	Ϋ́	1.44	09.0	4.94	1.72	4.82	1.55	5.09	2.19	5.12	2.30	1.16	3.16	2.73	2.58	3.63	3.46	0.24	3.07	2.55	2.63	15.46	2.87	NA	NA	lical Associa
Physi- cian Work	1.4.1	1.43	1.18	1.40	1.48	1.81	4.	1.32	1.18	1.68	1.75	1.46	1.45	1.48	1.81	1.50	1.63	18.1	1.27	0.75	1.85	1.29	1.41	86.0	2.20	1.54	1.90	1.33	1.36	1.12	1.22	2.20	1.35	1.58	0.18	2.33	2.29	2.38	7.07	1.78	8.15	4.37	American Mec
Description	N block inj, vagus	N block inj, phrenic	N block inj, spinal accessor	N block inj, cervical plexus	N block inj, brachial plexus	N block cont infuse, b plex	N block inj, axillary	N block inj, suprascapular	N block inj, intercost, sng	N block inj, intercost, mlt	N block inj. ilio-ing/hypogi	N block inj, pudendal	N block inj, paracervical	N block inj, sciatic, sng	N blk inj, sciatic, cont inf	N block inj fem, single	N block inj fem, cont inf	N block inj, lumbar plexus	N block, other peripheral	N block inj, plantar digit	Inj paravertebral c/t	Inj paravertebral c/t add-on	Inj paravertebral Vs	Inj paravertebral Vs add-on	Inj foramen epidural c/t	Inj foramen epidural add-on	Inj foramen epidural Vs	Inj foramen epidural add-on	N block, spenopalatine gangl	N block, caroud sinus s/p	N block, stellate ganglion	N block inj, hypogas plxs	N block, lumbar/thoracic	N block inj, celiac pelus	Apply neurostimulator	Implant neuroelectrodes	Implant neuroelectrodes	Implant neuroelectrodes	Implant neuroelectrodes	Implant neuroelectrodes	Implant neuroelectrodes	Implant neuroelectrodes	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved.
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2																																											CPT coc
CPT ¹³ /	64408	64410	64412	64413	64415	64416	64417	64418	64420	6442]	64425	64430	64435	64445	64446	64447	64448	64446	64450	64455	64470	64472	64475	64476	64479	64480	64483	64484	64505	64508	64510	64517	64520	64530	64550	64553	64555	64560	64561	64565	64573	64575	
in the second	060	060	060	060	060	060	060	060	222	060	060	060	060	060	060	060	060	222	060	000	060	060	222	010	060	060	010	010	060	060	060	060	060	060	060	060	060	060	060	000	000	000	
Mal- Practice DVIs-2-3-4 Global	•				10.30 090																										6.04 090											000 60:0	ights
	8.19	8.04	7.52	7.23	10.30	9.92	10.86	11.06	1.43	6.63	8.54	8.43	60'6	9116	18'6	6.29	9.46	1.15	0.91	2.37	4.68	2.71	86.0	0.50	2.73	0.85	0.93	0.85	4.71	5.24	6.04	6.84	2.64	3.36	3.68	3.21	1.65			80.0	60.0		ation. All Rights
Mal- Practice	18.92 8.19	18.65 8.04	17.84 7.52	17.36 7.23	22.58 10.30	22.33 9.92	23.61 10.86	23.96 11.06	2.46 1.43	16.53 6.63	19.62 8.54	19,42 8,43	18.40 9.09	20.69 9.16	21.81 9.81	13.70 6.29	15.87 9.46	2.43 1.15	6.86 0.91	1.68 2.37	8.55 4.68	7.68 2.71	1.79 0.98	3.11 0.50	9.02 2.73	4.89 0.85	3,43 0.93	3.96 0.85	12.71 4.71	13.62 5.24	15.89 6.04	17.26 6.84	9.37 2.64	10.88 3.36	10.92 3.68	9.59 3.21	1.65	6.91 2.22	6.67 1.97	0.65 0.08	0.73 0.09	0.74 0.09	dical Association. All Rights
Facility Mat- PE Practice 3 PVII-23 PVII-234 (NA 18.92 8.19	4 NA 18.65 8.04	NA 17.84 7.52	NA 17.36 7.23	NA 22.58 10.30	NA 22.33 9.92	NA 23.61 10.86	23.96 11.06	NA 2.46 1.43	NA 16.53 6.63	19.62 8.54	NA 19,42 8,43	NA 18.40 9.09	NA 20.69 9.16	NA 21.81 9.81	NA 13.70 6.29	15.87 9.46	NA 2.43 1.15	NA 6.86 0.91	14.04 1.68 2.37	NA 8.55 4.68	7.68 2.71	NA 1.79 0.98	3.11 0.50	9.02 2.73	NA 4.89 0.85	3,43 0.93	NA 3.96 0.85	NA 12.71 4.71	NA 13.62 5.24	15.89 6.04	NA 17.26 6.84	NA 9.37 2.64	10.88 3.36	10.92 3.68	NA 9.59 3.21	NA 5.71 1.65	6.91 2.22	NA 6.67 1.97	80.0 59.0 58.1	1.78 0.73 0.09	1.64 0.74 0.09	American Medical Association. All Rights
Non-Facility Mal-Facility Mal-F	nor 30,14 NA 18,92 8.19	29.84 NA 18.65 8.04	28.00 NA 17.84 7.52	NA 17.36 7.23	37.90 NA 22.58 10.30	37.47 NA 22.33 9.92	39.93 NA 23.61 10.86	40.67 NA 23.96 11.06	ect 5.25 NA 2.46 1.43	26.67 NA 16.53 6.63	31,42 NA 19,62 8,54	NA 19,42 8,43	NA 18.40 9.09	NA 20.69 9.16	NA 21.81 9.81	NA 13.70 6.29	NA 15.87 9.46	NA 2.43 1.15	NA 6.86 0.91	14.04 1.68 2.37	spinal cord 17.22 NA 8.55 4.68	NA 7.68 2.71	NA 1.79 0.98	NA 3.11 0.50	NA 9.02 2.73	NA 4.89 0.85	NA 3.43 0.93	NA 3.96 0.85	NA 12.71 4.71	NA 13.62 5.24	22,23 NA 15.89 6.04	NA 17.26 6.84	NA 9.37 2.64	NA 10.88 3.36	7 NA 10.92 3.68	NA 9.59 3.21	9.02 NA 5.71 1.65	NA 6.91 2.22	NA 6.67 1.97	1,11, 1.85 0.65 0.08	1.25 1.78 0.73 0.09	tal 1.32 1.64 0.74 0.09	sescriptions only are copyright 2009 American Medical Association. All Rights
Physic Non-cian Facility Mat- cian Facility Facility Mat- Work PE PE Practice Punica? Punica? Punica? Punica?	Biopsy/excise spinal tumor 30.14 NA 18.92 8.19	29.84 NA 18.65 8.04	28.00 NA 17.84 7.52	Biopsy/excise spiral tumor 26.61 NA 17.36 7.23	37.90 NA 22.58 10.30	37.47 NA 22.33 9.92	Biopsy/excise spinal tumor 39.93 NA 23.61 10.86	Biopsy/excise spinal tumor 40.67 NA 23.96 11.06	Repair of laminectomy defect 5.25 NA 2.46 1.43	26.67 NA 16.53 6.63	Removal of vertebral body 31,42 NA 19.62 8.54	Removal of vertebral body 31.00 NA 19.42 8.43	33.42 NA 18.40 9.09	Removal of vertebral body 33.70 NA 20.69 9.16	Removal of vertebral body 36.09 NA 21.81 9.81	Removal of vertebral body 35.40 NA 13.70 6.29	34.81 NA 15.87 9.46	5.24 NA 2.43 1.15	Remove spinal cord lesion 15.02 NA 6.86 0.91	8.72 14.04 1.68 2.37	spinal cord 17.22 NA 8.55 4.68	Srs, spinal lesion 10.79 NA 7.68 2.71	Srs, spinal lesion, addl 4.00 NA 1.79 0.98	Implant neuroelectrodes 4.18 NA 3.11 0.50	Implant neuroelectrodes 11,43 NA 9,02 2.73	Revise/remove neuroelectrode 6.87 NA 4.89 0.85	Instr/redo spine n generator 4.27 NA 3.43 0.93	Revise/remove neuroreceiver 5.25 NA 3.96 0.85	17.32 NA 12.71 4.71	Repair of spinal hemiation 19.26 NA 13.62 5.24	22,23 NA 15.89 6.04	25.15 NA 17.26 6.84	12.52 NA 9.37 2.64	15.52 NA 10.88 3.36	15.27 NA 10.92 3.68	12.50 NA 9.59 3.21	Install spinal shunt 9.02 NA 5.71 1.65	8.86 NA 6.91 2.22	Removal of spinal shunt 7.25 NA 6.67 1.97	N block inj, trigeminal 1.11 1.85 0.65 0.08	N block ini, facial 1.25 1.78 0.73 0.09	1.32 1.64 0.74 0.09	des and descriptions only are copyright 2009 American Medical Association. All Rights
Physic Non- Clan Facility Mal- clan Facility Facility Mal- Work PE P Practice Non-Male Physics	A Bionsy/excise spinal tumor 30.14 NA 18.92 8.19	29.84 NA 18.65 8.04	Biopsy/excise spinal tumor 28.00 NA 17.84 7.52	Biopsy/excise spiral tumor 26.61 NA 17.36 7.23	Biopsy/excise spinal tumor 37.90 NA 22.58 10.30	Biopsy/excise spinal tumor 37.47 NA 22.33 9.92	Biopsy/excise spinal tumor 39.93 NA 23.61 10.86	Biopsy/excise spinal tumor 40.67 NA 23.96 11.06	Repair of laminectomy defect 5.25 NA 2.46 1.43	Removal of vertebral body 26.67 NA 16.53 6.63	Removal of vertebral body 31,42 NA 19.62 8.54	Removal of vertebral body 31.00 NA 19.42 8.43	Removal of vertebral body 33.42 NA 18.40 9.09	Removal of vertebral body 33.70 NA 20.69 9.16	Removal of vertebral body 36.09 NA 21.81 9.81	Removal of vertebral body 35.40 NA 13.70 6.29	Removal of vertebral body 34.81 NA 15.87 9.46	Remove vertebral body add-on 5.24 NA 2.43 1.15	Remove spinal cord lesion 15.02 NA 6.86 0.91	Stimulation of spinal cord 8.72 14.04 1.68 2.37	Remove lesion of spinal cord 17.22 NA 8.55 4.68	Srs, spinal lesion 10.79 NA 7.68 2.71	Srs, spinal lesion, addl 4.00 NA 1.79 0.98	Implant neuroelectrodes 4.18 NA 3.11 0.50	Implant neuroelectrodes 11,43 NA 9,02 2.73	Revise/remove neuroelectrode 6.87 NA 4.89 0.85	Instr/redo spine n generator 4.27 NA 3.43 0.93	Revise/remove neuroreceiver 5.25 NA 3.96 0.85	Repair of spinal herniation 17.32 NA 12.71 4.71	Repair of spinal herniation 19.26 NA 13.62 5.24	Repair of spinal herniation 22,23 NA 15.89 6.04	Repair of spinal herniation 25.15 NA 17.26 6.84	Repair spinal fluid leakage 12.52 NA 9.37 2.64	Repair spinal fluid leakage 15.52 NA 10.88 3.36	Graft repair of spine defect 15.27 NA 10.92 3.68	Install spinal shunt 12.50 NA 9.59 3.21	Install spinal shunt 9.02 NA 5.71 1.65	Revision of spinal shunt 8.86 NA 6.91 2.22	Removal of spinal shunt 7.25 NA 6.67 1.97	N block inj, trigeminal 1.11 1.85 0.65 0.08	N block ini, facial 1.25 1.78 0.73 0.09	1.32 1.64 0.74 0.09	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved

Reserved.

The plant are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 89840, 9841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

Trivites are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payanent.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

CPT ^{1,2}				Physi- cian Work	Non- Facility PE	Facility	Mal- Practice		CPT.3/			Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice	
HCPCS	Mod	Statue	Description	KVUs.	RVUs	RVUS	KVUs	Global	HCPCS Mod	ñ	Description	RVUs"	RVUs.	RVUs.	KVU8""	Cloba
04577		∢ .	Impiani neuroelectrodes	40.4	Y ;	0.10	07.1	060	04/47	₹ ·	incision of facial nerve	6.75	¥.	0.00	55.0	060
64580		₹.	Implant neuroelectrodes	4.14	NA.	3.38	0.67	960	64744	<	incise nerve, back of head	5.64	K K	5.78	1.33	060
64581		∢,	Implant neuroelectrodes	14.15	Ν	5.75	<u>~</u>	060	64746	¥	Incise diaphragm nerve	6.46	Y.	5.09	1.15	060
64585		¥	Revise/remove neuroelectrode	2.08	4.06	1.59	0.18	010	64752	4	Incision of vagus nerve	7.59	NA V	4.50	1.35	060
64590		¥	Insrt/redo pn/gastr stimul	2.42	4.05	1.64	0.19	010	64755	٧	Incision of stomach nerves	14.97	A'N	7.80	2.42	060
64595		Ą	Revise/rmv pn/gastr stimul	1.75	4.26	1.44	0.14	010	64760	¥	Incision of vagus nerve	7.49	Y Y	5.16	1.21	060
64600		∢	Injection treatment of nerve	3.46	6.70	2.24	0.27	010	64761	٧	Incision of pelvis nerve	6.94	NA A	4.63	0.75	060
64605		٧	Injection treatment of nerve	5.62	13,80	4.10	1.53	010	64763	¥	Incise hip/thigh nerve	7.46	Ϋ́Z	5.06	1.21	060
64610		∢	Injection treatment of nerve	7.17	1.04	4.40	1.58	010	64766	٧	Incise hip/thigh nerve	9.34	A'A	90.9	0.68	060
64612		٧	Destroy nerve, face muscle	1.98	2.14	1.84	0.12	010	64771	4	Sever cranial nerve	8.02	NA A	60.9	87.0	060
64613		∢	Destroy nerve, neck muscle	1.98	1.92	1.60	0.15	010	64772	∢	Incision of spinal nerve	7.74	NA	6.42	1.36	060
64614		4	Destroy nerve, extrem musc	2.20	2.18	1.75	0.13	010	64774	Y	Remove skin nerve lesion	5.70	NA	4.73	77.0	060
64620		٧	Injection treatment of nerve	2.86	4.75	1.78	0.21	010	64776	¥	Remove digit nerve lesion	5.52	ΝA	4.40	0.63	060
64622		A	Destr paravertebri nerve I/s	3.02	5.87	2.06	0.18	010	64778	٧	Digit nerve surgery add-on	3.11	NA	1.53	0.47	222
64623		٧	Destr paravertebral n add-on	66'0	2.35	0.41	90.0	222	64782	Ą	Remove limb nerve lesion	92.9	NA	4.91	89.0	960
64626		<	Destr paravertebr] nerve c/t	3.82	6.83	2.98	0.23	010	64783	¥	Limb nerve surgery add-on	3.71	NA	2.10	0.35	777
64627		∢	Destr paravertebral n add-on	1.16	3.35	0.48	0.07	222	64784	¥	Remove nerve lesion	10.49	NA	7.87	1.51	060
64630		<	Injection treatment of nerve	3.02	2.56	1.72	0.22	010	64786	¥	Remove sciatic nerve lesion	16.12	NA	10.80	2.41	060
64632		¥	N block inj, common digit	1.20	1.09	0.70	0.02	010	64787	٧	Implant nerve end	4.29	NA	1.96	0.52	222
64640		∢	Injection treatment of nerve	2.78	2.72	1.59	0.15	010	64788	∢	Remove skin nerve fesion	5.14	N.A	4.68	080	060
64650		٧	Chemodenery eccrine glands	0.70	1.14	0.35	0.04	000	64790	V	Removal of nerve lesion	11.97	NA	8.48	2.06	060
64653		4	Chemodenery eccrine glands	0.88	1,32	0.39	90.0	000	64792	٧	Removal of nerve lesion	15.71	NA	11.78	4.27	060
64680		٧	Injection treatment of nerve	2.64	5.39	- 49.	0.20	010	64795	Ą	Biopsy of nerve	3.01	۲ Z	1.81	0.55	900
64681		¥	Injection treatment of nerve	3.78	4.94	1.20	0.23	010	64802	¥	Remove sympathetic nerves	10.24	Ϋ́	7.13	0.62	060
64702		٧	Revise finger/toe nerve	6.10	ΝA	6.29	0.78	060	64804	¥	Remove sympathetic nerves	15.78	ΝA	4.18	0.95	060
64704		¥	Revise hand/foot nerve	4.61	NA	3.68	0.40	060	64809	¥	Remove sympathetic nerves	14.61	NA	3.80	0.88	060
64708		¥	Revise arm/leg nerve	7.36	Ϋ́	6.54	98.0	060	64818	¥	Remove sympathetic nerves	11.24	Z,	5.47	1.65	060
64712		¥	Revision of sciatic nerve	7.98	NA	5.80	1.00	060	64820	∢	Remove sympathetic nerves	10.64	Z,	8.42	1.43	060
64713		∢	Revision of ann nerve(s)	11.29	NA	7.80	1.80	060	64821	٧	Remove sympathetic nerves	9.19	Ν	7.85	1.38	060
64714		٧	Revise low back nerve(s)	10.44	NA	7.18	1.36	060	64822	¥	Remove sympathetic nerves	61.6	NA	7.85	1.38	060
64716		٧	Revision of cranial nerve	98.9	NA	6.52	0.80	060	64823	4	Remove sympathetic nerves	10.80	NA	8.64	1.62	060
64718		∢	Revise ulnar nerve at elbow	7.06	NA	7.39	1.09	060	64831	٧	Repair of digit nerve	9.74	NA A	8.45	1.23	060
64719		¥	Revise ulnar nerve at wrist	4.89	NA	4.97	0.70	060	64832	K	Repair nerve add-on	5.65	NA	3.01	0.75	ZZZ
64721		¥	Carpal tunnel surgery	4.84	5.61	5.55	0.72	060	64834	A	Repair of hand or foot nerve	10.71	V.	7.99	1.38	060
64722		₹	Relieve pressure on nerve(s)	4.74	Y.	3.98	0.55	060	64835	Α.	Repair of hand or foot nerve	11.60	X :	8.58	7.1	060
64726		۷	Release foot/toe nerve	4.21	Y :	2.95	0.29	060	64836	∢ .	Repair of hand or foot nerve	11.60	V.	82.8	1.74	960
64727		∢	Internal nerve revision	3.10	V.	1.54	0.45	777	64837	¥	Repair nerve add-on	6.25	K :	3,55	6.94	777
64732		< -	Incision of brow nerve	8.	YZ :	5.39	E.;	060	64840	∢ .	Repair of leginerye	13.87	KZ :	5.56	0.75	060
64734		٧	Incision of cheek nerve	5.45	K Z	60.0	1.48	060	64856	ď	Kepair/transpose nerve	14.94	ď Z	10.63	7.14	060
64736		∢	Incision of chin nerve	5.13	NA	5.94	1.39	060	64857	< ∙	Repair arm/leg nerve	15.69	Y.	90 :	2.17	060
64738		⋖	Incision of jaw nerve	97.9	A	6.47	1.70	060	64858	V.	Repair sciatic nerve	17.69	Y.	11.67	2.65	069
64740		¥	Incision of tongue nerve	6.12	NA	5.70	09.0	060	64859	¥	Nerve surgery	4.25	۷ Z	5.09	0.64	777
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	If valu	ies are re	If values are reflected for codes not payable by Medicare, please note that	re, please no	te that these	these values have been	peen		, If v	alues are ref	If values are reflected for codes not payable by Medicare, please note that these values have been	are, please note	that these v	alues have b	en E	
	The bu	neo as a c ideet neu	estabusined as a courtesy to the general public and are not used for incurrant. The budget neutrality reduction from the chiropractic demonstration is not	lemonstration	is not refle	payment. reflected in the R	payment. reflected in the RVUs for CPT		The	budget neul	estabilismed as a courtes) to the general public and are not used for predicate payment. The budget neutrality reduction from the chirocractic demonstration is not reflected in the RVUs for CPT	demonstration	ulcare payme	nt. Solin the RV	Us for CPT	
	codes 98	8940, 989	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	the files use	d for		apao	s 98940, 989	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	a will only be r	eflected in the	e files used	for	
	Medicar	Medicare payment.	ent.	:					Med	Medicare payment		;				
	. Clobal	totals fo	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.					95.	bal totals for	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				

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CPT ^{1,2})				Physi- cian Work	Non- Facility PE	Facility PE	Mai		CPT'3/			Physi- cian Work	Non- Facility PE	Facility	Mai- Practice	,
HCPCS	Mod	Status	Description	RVUs.	RVUs.	RVUs.	RVUs.		HCPCS Mod	d Statue	Description	KVU8.7	KVU8	9044	200 004	9
64861		< <	Repair of arm nerves	20.04	Y Z	15.40	5.64	060	65210	₹ 4	Remove foreign body from eye	0.71	10.0	0.57	0.0	
70960		< ∢	Repair of facial nerve	13.31	Y Y	800	1.30		65220	: <	Remove foreign body from eve	0.71	0.76	0.39	0.05	
64865		: ∢	Repair of facial nerve	15.96	Ϋ́	13.11	1.56		65222	< <	Remove foreign body from eye	0.93	1.02	0.61	0.04	
64866		٧	Fusion of facial/other nerve	16.70	NA	16.31	1.63		55235	A	Remove foreign body from eye	8.78	Ϋ́	9.21	0.46	
64868		٧	Fusion of facial/other nerve	14.80	NA	11.86	1.44) 060	65260	٧	Remove foreign body from eye	12.29	V.	12.14	0.64	
64870		4	Fusion of facial/other nerve	16.95	NA	10.21	3.01		65265	V	Remove foreign body from eye	14.06	¥.	13.49	0.74	
64872		4	Subsequent repair of nerve	1.99	NA	1.13	0.19		65270	¥	Repair of eye wound	1.92	4.62	0.70	0.09	
64874		<	Repair & revise nerve add-on	2.98	Y.	04.	0.81		65272	∢ .	Repair of eye wound	4.49	7.92	4,42	0.23	
64876		Y	Repair nerve/shonen bone	3.37	Y :	2.01	0.50		65273	∢ .	Repair of eye wound	5.03	V V	4.68	0.20	
64885		∢	Nerve graft, head or neck	17.50	YZ :	11.20	1.71		65275	∢ •	Repair of eye wound	6.14	8.36	0.00	0.52	
64886		≺ ·	Nerve graft, head or neck	20.72	¥ ;	12.76	2.02		65280	< <	Repair of eye wound	8.8/	K &	8.23	0.47	
64890		< <	Nerve graff, band of 1001	10.11	K Z	10.60	2.41		65286	< <	Repair of eve wound	6.45	86'01	6.15	0.34	
64897		< ∢	Nerve grant, name of root	15.61	t V	10.55	2.34		65290	: <	Repair of eye socket wound	6.35	N.	6.11	0.33	
64893		< 4	Nerve graft, arm or leg	16.74	Ϋ́	11.20	121		65400	<	Removal of eye lesion	7.27	9.71	7.93	0.38	
64895		<	Nerve graft, hand or foot	20.26	NA	12.93	3.03		65410	A	Biopsy of comea	1.47	2.13	1.24	0.07	
64896		4	Nerve graft, hand or foot	21.81	NA	15.48	5.93		65420	Ą	Removal of eye lesion	4.24	8.47	5.25	0.22	
64897		4	Nerve graft, arm or leg	19.25	ΝA	12.44	2.88		65426	٧	Removal of eye lesion	5.93	10.27	6.24	0.31	
64898		4	Nerve graft, arm or leg	20.82	NA	13.50	3.12		5430	¥	Corneal smear	1.47	1.48	1.22	0.07	
64901		<	Nerve graft add-on	10.20	NA	60.9	1.53		65435	∀	Curette/treat comea	0.92	1.12	0.88	0.04	
64902		4	Nerve graft add-on	11.81	NA	7.05	1.77		65436	∢	Curette/treat cornea	4.72	2.1	4.74	0.25	
64905		۷	Nerve pedicle transfer	14.98	ΑN	11.47	2.24		5450	Α.	Treatment of corneal lesion	3.35	4.74	4.66	0.18 0.00	
64907		¥	Nerve pedicle transfer	19.90	NA	9.17	1.07		65600	∢ ·	Revision of comea	4.07	4.0	80.4	77.0	
64910		٧	Nerve repair w/allograft	11.21	YY ;	9.64	1.47		65710	∢ •	Corneal transplant	14.09	K	14.00	5,73	
64911		٧	Neurorraphy w/vem autograft	[4.2]	Υ Ş	11.84	2.13		02/30	∢ •	Corneal transplant	5.59	¥ 2	15.03	0.03	
64999		ပ -	Nervous system surgery	0,00	0.00	00:0	0.00	777	05/59	₹ 4	Corneal transplant	16.49	K	15.00	0.00	
16069		< 4	Nevice eye Davise eye with implant	6.63	(A	8.90	38.0		65756	< <	Corneal traspl. endothelial	16.60	X X	13.96	68.0	
65101		< <	Removal of eve	8.10	X Y	10.42	0.42	060	65757	ပ	Prep comeal endo allografi	00.0	NA.	00.0	00.0	•
65103		<	Remove eye/insert implant	8.64	NA	10.71	0.46		65770	¥	Revise cornea with implant	19.41	NA	16.73	1.03	
65105		4	Remove eye/attach implant	9.70	NA	11.68	0.53		65772	∢	Correction of astigmatism	4.96	6.36	5.33	0.26	
65110		٧	Removal of eye	15.42	NA	15.38	1.00		65775	٧	Correction of astigmatism	6.73	NA A	7.22	0.35	
65112		4	Remove eye/revise socket	18.18	NA	17.96	0.95	060	65780	∢ ·	Ocular reconst, transplant	10.43	¥:	11.92	0.55	
65114		4	Remove eye/revise socket	19.32	Y .	18.64	00:1		65781	∢ -	Ocular reconst, transplant	17.84	e s	16.41	66.0	
65125		∢ .	Revise ocular implant	37.00	7.57	4.15	0.17		65782	Κ ₹	Ocular reconst, transplant	15.16	A 2	14.34	0.80	
65135		∢ ∢	Insert ocular implant	8.40	Z Z	10.17	24.0	060	65805	< ∢	Drainage of eve	6	2.26	1.51	60:0	
65139		: 4	Attach ocular implant	9 23	Z	1 00	0.48		65810	<	Drainage of eve	5.67	¥Z.	6.29	0.30	
05150		< ∢	Revise ocular implant	6.32	N.	8.22	0,33	060	65815	< <	Drainage of eye	5.85	96.6	6.24	0.31	
95159		. <	Reinsert ocular implant	6.87	Ϋ́	11.47	0.51		65820	¥	Relieve inner eye pressure	8.72	Ϋ́	10.22	0.45	
65175		<	Removal of ocular implant	7.22	AN	9.23	0.38		65850	¥	Incision of eye	11.24	NA	10.34	0.59	
	CPTe	odes and	³ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Mex	dical Associa	ntion. All Rig	hts		 	T codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	cal Associati	on, All Righ	ıts	
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	establish	hed as a v	is a family as a courtey to the general public and are not used for Medicare payment. 3. The budges neutrality reducting from from the chinometric demonstration is not reflected in the RVUIs for CPT.	ot used for M	fedicare pay.	nent.	Us for CPT		esta	blished as a	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chirograchic demonstration is not reflected in the RVUs for CPT	t used for Mer emonstration	dicare payme is not reflecte	nt. id in the RV	Us for CPT	
	codes 98	8940,98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	a will only be	reflected in	the files used	1 for		code	ss 98940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be r	effected in th	e files used	for	
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The All Tradues are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 98940, 9841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R VUs may not sum due to rounding.

re1140				Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice		CPT ¹³		:	Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice	4
HCPCS	Mod	Status	Description	RVUs ^{2,3}	RVUs.	RVUs*	RVUs.	Global		Mod Status	Description interception	SO O	9 V	10.36	0.46	000
65855		٧	Laser surgery of eye	3.90	4.05	3.09	0.18	010	67900	۲.	reposition intraocular tens	70.0	5 2	0.03	9.0	000
09859		٧	Incise inner eye adhesions	3.56	4.32	3.01	61.0	060	668.30	< -	Kemoval of lens lesion	17.6	Z ;	0.00	0.0	
65865		٧	Incise inner eye adhesions	5.66	NA NA	6.34	0.29	060	66840	∢ •	Kemoval of lens material	8.98	۲ ·	0.00	(+)0	960
65870		٧	Incise inner eye adhesions	7.21	NA A	7.75	0.38	060	06899	∢ •	Kemovai of lens material	10.32	ξ χ	1.50	550	000
65875		Ą	Incise inner eye adhesions	7.61	NA	8.32	0.40	060	26892	∢ ⋅	Kemoval of lens material	11.10	۲ × ۲ ۶	92.0	0.30	000
08859		٧	Incise uner eye adhesions	8.16	N A	8.63	0.42	060	66920	< -	Extraction of lens	9.93	۲ :	9.30	0.52	260
00659		4	Remove eye lesion	12.26	NA	12.32	0.64	060	66930	∢	Extraction of lens	11.38	ď.	10.52	0.59	260
65920		٧	Remove implant of eye	9.74	NA	10.22	0.51	060	66940	¥	Extraction of lens	10.14	ď ;	08.6	0.53	060
65930		٧	Remove blood clot from eye	8.24	NA	8.03	0.43	060	66982	∢	Cataract surgery, complex	4.83	₹ ;	12.41	0.77	260
66020		٧	Injection treatment of eye	19:1	3.01	1.73	0.07	010	686983	¥	Cataract surg w/iol, 1 stage	10.20	YZ.	8.82	0.53	060
66030		<	Injection treatment of eye	1.27	2.80	1.53	90.0	010	66984	۷	Cataract surg w/iol, l stage	10.36	NA V	9.19	0.54	060
66130		₹	Remove eye lesion	7.74	68'6	6.94	0.40	060	66985	¥	Insert lens prosthesis	9.73	NA	9,83	0.51	060
66150		< <	Glaucoma surgery	10.18	NA	11.82	0.53	060	98699	<	Exchange lens prosthesis	12.26	NA	11.36	0.64	060
66155		4	Glancoma surgery	10.17	NA	18.11	0.53	060	06699	K	Ophthalmic endoscope add-on	1.51	NA V	06.0	0.07	777
09199		¥	Glaucoma surgery	12.04	NA	12.92	0.63	060	66699	Ç	Eye surgery procedure	0.00	0.00	0.00	0.00	<u>}</u>
66165		<	Glaucoma surgery	68.6	ΥN	11.65	0.51	060	67005	Y	Partial removal of eye fluid	5.77	Y Y	6.22	0.30	060
02199		<	Glaucoma surgery	14.57	ΝA	15.71	0.76	060	01019	K	Partial removal of eye fluid	6.94	Y Z	16'9	0.36	060
22199		<	Incision of eve	18.26	NA	19.88	\$6.0	060	67015	۷	Release of eye fluid	7.00	ΥZ	7.71	0.37	060
66180		. ∢	Implant eve shint	16.02	NA	13.91	0.83	060	67025	∢	Replace eye fluid	7.91	10.29	8.12	0.41	060
66185		: ≺	Revise eve shunt	9.35	Ν	89.6	0.49	060	67027	Ą	Implant eye drug system	11.43	ΝA	10.42	09.0	060
02299		; ∢	Repair eve lesion	86.8	NA	9.85	0.47	060	67028	4	Injection eye drug	2.52	2.89	1.87	0.12	000
\$6633		: ∢	Renair/oraft eve lesion	12.38	NA	11.48	0.65	060	67030	<	Incise inner eye strands	16'5	۷.	7.41	0.31	060
05 299		< ≺	Follow-up surgery of eye	6.92	11.64	7.20	0.36	060	67031	∢	Laser surgery, eye strands	4.34	5.41	4.66	0.23	060
00599		<	Incision of iris	3.75	NA	5.14	0.20	060	67036	Y	Removal of inner eye fluid	13.09	NA	11.54	89.0	060
66505		: ≺	Incision of iris	4.13	NA	19:5	0.21	060	62039	<	Laser treatment of retina	16.39	NA	15.15	0.85	060
00999		×	Remove iris and lesion	68.6	NA	11.17	0.51	060	67040	<	Laser treatment of retina	19.23	NA	17.13	1.00	060
66605		< <	Removal of tris	13.99	NA	13.13	0.73	060	67041	V	Vit for macular pucker	19.00	NA	15.27	0.99	060
50000		: ∢	Removal of tris	5.19	ΝA	5.70	0.27	060	67042	٧	Vit for macular hole	22.13	NA	17.14	1.15	060
66630		. ≺	Removal of iris	7.10	NA	7.35	0.37	060	67043	¥	Vit for membrane dissect	22.94	NA	18.28	1.20	060
66635		: <	Removal of iris	7.19	Ν	7.40	0.37	060	67101	Ą	Repair detached retina	8.60	11.13	8.55	0.45	060
08999		<	Repair iris & ciliary body	6.24	NA	6.85	0.33	060	67105	∢	Repair detached retina	8.35	68'6	80.8	0.43	060
66682		¥	Repair iris & ciliary body	7.15	Ν	8.87	0.37	. 060	67107	Y	 Repair detached retina 	16.35	NA	14.73	0.85	060
90299		4	Destruction, ciliary body	5.06	6.34	5.01	0.26	060	801.09	4	Repair detached retina	22.49	Z	90.5	71.1	060
66710		*	Ciliary transsleral therapy	5.06	6.11	5.00	0.27	060	67110	Y	Repair detached retina	10.02	11.90	9.7	0.52	060
66711		4	Ciliary endoscopic ablation	7.70	NA	8.53	0.40	060	67112	¥	Rerepair detached retina	18.45	Y.	15.68	96.0	060
66720		ď	Destruction, ciliary body	4.86	6.91	5.72	0.28	060	67113	۷	Repair retinal detach, cplx	25.00	NA	20.10	1.30	060
66740		∢	Destruction, ciliary body	5.06	6.04	10.5	0.26	060	67115	A	Release encircling material	5.93	Y.	99.9	0.31	960
19299		*	Revision of iris	4.87	6.54	5.62	0.25	060	67120	Ą	Remove eye implant material	6.92	9.52	7.21	0.36	060
66762		<	Revision of iris	5.25	6.71	5.56	0.27	060	67121	¥	Remove eye implant material	12.00	Y.	11.22	0.63	060
0/1/99		∢	Removal of inner eye lesion	5.98	7.34	6.29	0.31	060	67141	¥	Treatment of retina	90.9	7.21	6.36	0.31	060
66820		٧	Incision, secondary cataract	3.93	NA	5.92	0.20	060	67145	Ą	Treatment of retina	6.17	7.16	6.46	0.32	060
66821		¥	After cataract laser surgery	3.32	4.91	4.46	0.17	060	67208	A	Treatment of retinal lesion	7.50	7.76	7.26	0.39	060
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	codes 9	18940, 985	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	a will only be	reflected it	the files use	d for		ឌ	des 98940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be	reflected in	he files used	for	
	Medica	ere payme.	Medicare payment.						Σ.,	Medicare payment	int.	7				
	⁴ Globa	ıl totals fo	or malpractice RVUs may not sum due	to rounding.						Global totais re	Global totals for majpractice RVUs may not sum due to rounding.	to rounding.				

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Facility PE PE	4 8 4 5	000	99 1			127	75	2.01	4.82	0.88	99.0	1.67	1.79	5.62	2.00	1.75	1.18	4.83	6.10	6.31	7.27	8.85	90.9	7.46	6.25	5.60	2.68	7.02	6.25	3.67	3.26	5.61	6.0	3.51	3.15	5.96	\$9.5	7.66	5.13	1.58	5.93	5.85	ciation. Al	se values h
Non- Facility PE	e Z	000	90.5	3.5	4 45	28.1	274	2.87	Y	3.84	0.60	1.82	4.76	NA	4.70	3.60	2.90	9	8.22	9.36	11,36	Ϋ́	8.53	10.57	Y'A	7.19	7.93	NA	15.41	5.97	5.38	8.07	8.61	5.80	5.22	8.31	8.82	5.55	8.64	4.53	8.45	8.64	edical Asso	ote that the
Physi- cian Work	14.21	900	1 37		201	50.1	68	2.24	4.47	1.48	0.71	1.40	1.72	19.5	2.06	1.71	1.35	4.47	5.87	69.9	7.47	89.6	6.42	7.83	6.84	5.19	5.46	7.38	6.23	3.70	3.21	5.37	6.08	3.42	3.09	5.94	5.84	3.62	6.27	1.35	5.88	5.75	9 American M	dicare, please r
. And Substitute of Substitute	Decompress ontic nerve	Orbit surgery procedure	Designation of executary	Leading of cyclic aparcas	Indicion of excelled fold	Remove evelid lesion	Remove evelid lesions	Remove evelid lesions	Remove evelid lesion(s)	Biopsy of eyelid	Revise eyelashes	Revise eyelashes	Revise eyelashes	Revise eyelashes	Remove eyelid lesion	Treat eyelid lesion	Closure of eyelid by suture	Revision of eyelid	Revision of eyelid	Repair brow defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Revise eyelid defect	Revise eyelid defect	Correction eyelid w/implant	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid defect	Repair eyelid wound	Repair eyelid wound	Remove eyelid foreign body	Revision of eyelid	Revision of eyelid	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights reserved	If values are reflected for codes not payable by Medicare, please note that these values have been
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(*1742)	HCPC)	00579	00227	0.170	31773	00829	10878	67805	67808	67810	67820	67825	67830	67835	67840	67850	67875	08829	67882	00629	10629	67902	67903	40629	90629	80629	60629	67911	67912	67914	61619	91629	67917	67921	67922	67923	67924	67930	67935	67938	05629	19629		
į	000	060	000	060	277	770	8	060	060	060	YYY	060	060	060	060	060	222	777	272	777	222	777	060	010	000	٨٨٨	060	060	060	060	060	000	060	060	060	060	060	000	000	000	060	060		
Mal- Practice	KVU8	501	5.6	0.74	0.10	20.0	250	0.83	0.49	0.52	0.00	0.40	0.50	0.45	0.57	0,46	0.25	0.24	0.26	0.23	0.12	0.28	0.45	0.17	0.13	000	0.63	0.52	0.58	0.61	0.95	80.0	1.25	0.78	0.76	1.05	0.79	0.08	90'0	90'0	0.83	0.73	ghts	been
Facility PE	7 80	16.87	13.02	10.01	17.7	2.10	14.03	13.50	10.40	11.33	0.00	19.7	8.75	8.53	9.73	9.04	3.19	3.01	3.29	3.00	1.47	3.56	8.30	2.41	2.38	0.00	12.56	10.95	11.46	11.63	16.38	40.1	18.61	16.62	16.04	17,13	16.69	0.68	0.88	96.0	12.90	13.05	ttion. All R	lease note that these values have been
Non- Facility PE	KVUS.	74.0 V V	20 61	0.00	25.0	20.0	17.81	N.A.	Ϋ́	NA NA	0.00	ΝĀ	NA	NA	NA	Ν	NA	Ν	Ν	NA	Ν	ΝA	NA	2.95	ΝA	0.00	NA	Y.	NA	NA	NA	NA	Ϋ́Z	Ϋ́	ΥN	Ν	NA	0.85	90'1	1.14	NA	NA	dical Associ	ste that these
Physi- clan Work	**V08	70.55	27:07	4.19	0.40	7 3 5	13.67	16.00	9.46	76.6	0.00	7.59	9.48	8.59	10.73	8.92	5.40	5.13	5.56	5.05	2.49	9.00	8,29	2.98	2.87	0.00	10.97	00.6	10.17	10.09	17.78	1.76	21.62	14.99	14.56	18.96	15.11	1.44	1.27	1.40	11.52	11.93	American Me	-
: :	Description	Treatment of return lesion	reduicit of fermal teston	reatment of enoroid resion	Ocurar photodynamic aret	Eye protocytamic met aug-on Teatment of entirel legion	Treatment of ration legion	Trefinal les preferm inf	Reinforce eve wall	Reinforce/graft eye wall	Eye surgery procedure	Revise eye muscle	Revise two eye muscles	Revise eye muscle	Revise two eye muscles	Revise eye muscle(s)	Revise eye muscle(s) add-on	Eye surgery follow-up add-on	Rerevise eye muscles add-on	Revise eye muscle w/suture	Eye suture during surgery	Revise eye muscle add-on	Release eye tissue	Destroy nerve of eye muscle	Biopsy, eye muscle	Eye muscle surgery procedure	Explore/biopsy eye socket	Explore/drain eye socket	Explore/treat eye socket	Explore/treat eye socket	Explr/decompress eye socket	Aspiration, orbital contents	Explore/treat eye socket	Explore/treat eye socket	Explore/drain eye socket	Explr/decompress eye socket	Explore/biopsy eye socket	Inject/treat eye socket	Inject/treat eye socket	Inject/treat eye socket	Insert eye socket implant	Revise eye socket implant	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Action with the same reflected for codes not payable by Medicare
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² If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

² The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 498941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

⁴ Global totals for malpractice R VUs may not sum due to rounding.

Yealuses are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

	CPT'3/		i		Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice		CPT ^{1,3} /		į	a city in the city of the city	Physician Cian Work	Non- Facility PE PE	Facility PE DVII-2.3	Mat- Practice	ē
A Reconstruction of spelled 9.37 N.03 6.07 6.09 6.07 A Reconstruction of spelled 9.37 N.03 6.09 6.00 6.00 A Reconstruction of spelled image 12.96 N.A 11.10 0.73 6.09 6.881 A Reconstruction of spelled liming 12.99 N.A 1.10 0.00 0.00 7.77 6.00 6.881 A Reconstruction of spelled liming 0.00 0.00 0.00 0.00 0.00 6.881 A Remove expelled liming 0.03 0.82 0.04 0.00 6.881 A Remove expelled liming 1.35 2.85 1.29 0.00 6.00 6.888 A Remove expelled liming 1.35 2.85 1.29 0.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	CPCS	DOM:	Status		S C C	NV08	80 o	80.0	000				Tong tong dust desired	000	2 20	691	90.0	5 ~
A Reconstruction of speid and speid	996/		∢ .	Kevision of eyella	0.00	0.01	0.00	25.0	060	02.00			The test duct opening	000	V V	60.7	0.00	, ,
A Reconstruction of eyelid (12.99 NA) 11.10 (17.0 090) 68810 (17.0 NA) (17.0 NA) (17.0 090) 68810 (17.0 NA) (17.0	1/6/		∢	Reconstruction of eyeud	10.6	ď,	0.70	40.0	060	07.00			tope teal system ustaid	9.03			24.0	, ,
A Reconstruction of spelled and spelled a	7973		∢	Reconstruction of eyelid	96.71	۲ ;	01.1	0.75	060	10880			hiate tear duct opening	0.96	2.13	C/-1	0.03	,
C Revision of eyelid 9.21 NA 8.39 0.44 0.00 6.04 0.04 6.04 0.04 6.04 0.04 6.04 0.04	1974		٧	Reconstruction of eyelid	12.93	Y.	1.06	0.70	040	01889			robe nasolacrimal duct	5.09	3,88	10.7	0.10	9 0
A Treat-eyclid luring lesion of 2,38	57975		V	Reconstruction of eyelid	9.21	N.	8.39	0.54	060	11889		ν,	robe nasolacrimal duct	2.39	NA S	7.87	0.12	5 0
A interception beyond facinity and the control of the chipprate of control of the c	57999		ပ	Revision of eyelid	0.00	0.00	0.00	0.00	۲۲۲	68815		Ą	robe nasolacrimal duct	3.24	7.75	3.32	0.16	υ,
A Treatment of eyeld lating serior 135 282 034 004 000 68834 A Remove eyeld lating lesion 136 136 120 037 000 000 68899 A Remove eyeld lating lesion 139 136 120 037 000 000 68899 A Remove eyeld lating lesion 139 136 130 037 000 000 0000 A Reveised eyeld lating lesion 149 135 136 136 000 000 0000 A Reveised eyeld lating lesion 149 137 136 036 000 000 0000 A Reveised eyeld lating lesion 149 137 136 036 000 000 0000 A Reveised eyeld lating lesion 149 137 036 000 000 0000 A Reveised eyeld lating lesion 149 148 131 049 000 000 0000 A Reveised eyeld lating 843 NA 819 044 000 000 000 000 0000 A Reveised eyeld lating 843 NA 819 044 000 000 000 000 000 000 000 000 00	68020		4	Incise/drain eyelid lining	1.39	1.62	14.1	90.0	010	91889		A	robe nl duct w/balloon	3.00	14.79	3.38	0.16	0
A Biogray of Pecula luming lesion 179 3.78 120 0.07 0.00 68899 A Remove eyelid luming lesion 1.79 3.78 120 0.07 0.00 68899 A Remove eyelid luming lesion 1.29 3.78 120 0.02 0.00 0.00 0.00 0.00 0.00 0.00	68040		٧	Treatment of eyelid lesions	0.85	0.82	0.54	0.04	000	68840		A	aplore/irrigate tear ducts	1.27	1,92	99:1	90.0	0
A Remove eyelid lining lesion 179 3.76 199 008 009 069000 A Remove eyelid lining lesion 4.99 8.39 5.47 011 010 000 069000 A Remove eyelid lining lesion 1.89 1.37 1.10 0.02 000 000 069000 A Remove eyelid lining lesion 1.84 1.14 1.14 0.15 0.02 000 000 069100 A Revisegraft eyelid lining 8.43 NA 8.13 0.44 0.09 000 069100 A Revisegraft eyelid lining 8.43 NA 8.13 0.44 0.09 000 069110 A Revisegraft eyelid lining 8.43 NA 8.13 0.04 0.00 000 069110 A Revisegraft eyelid lining 8.22 NA 8.13 0.04 0.00 000 069110 A Revisegraft eyelid lining 8.22 NA 8.13 0.04 0.00 000 069110 A Revise eyelid lining 8.22 NA 8.23 0.00 0.02 0.00 069110 A Revise eyelid lining 8.22 NA 8.24 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	00189		¥	Biopsy of eyelid lining	1.35	2.85	1.20	0.07	000	68850		A	njection for tear sac x-ray	0.80	0.77	0.65	0.05	0
A Remove eyeld timing lesion 133 5.28 14 0.11 0.10 660000 A Remove eyeld timing lesion 146 0.12 0.12 0.00 0.00 0.00 0.00 0.00 0.00	01189		٧	Remove eyelid lining lesion	1.79	3.76	1.99	80.0	010	68899		Ç	ear duct system surgery	0.00	0.00	0.00	0.00	>
A Remove eyeled lutting lesion 4.99 8.39 5.47 0.05 6900 A A remove eyeled lutting lesion 4.99 8.39 5.47 0.05 690 69010 A A remove eyeled lutting lesion 6.44 1.48 2.12 1.99 0.09 6910 6910 A Revisegraf by eyeld lutting 6.44 1.48 1.16 0.44 699 69110 A Revisegraf by eyeld lutting 8.22 NA 8.87 0.44 699 69110 A Revisegraf by eyeld lutting 8.22 NA 8.87 0.44 699 69110 A Revisegraf by eyeld lutting 8.22 NA 8.86 0.61 690 69110 A Revise eyeld lutting 8.25 NA 8.24 0.44 699 69110 A Revise eyeld lutting 8.25 NA 8.24 0.44 699 69110 A Revise eyeld lutting 8.25 9.27 0.2	68115		<	Remove eyelid lining lesion	2.38	5.28	2.34	0.11	010	00069		A	Jrain external ear lesion	1.47	3.21	1.58	0.10	0
A Revise/graft eyelid luning lesion 1.86 2.12 1.99 0.09 0.00 6.90 0.00 0.00 0.00 0.00 0	68130		¥	Remove eyelid lining lesion	4.99	8.39	5.47	0.26	060	\$0069		٧	Jrain external ear fesion	2.13	3.33	1.92	0.15	0
A Revise/graft cyclid lining 644 1145 715 636 000 60100 A Revise/graft cyclid lining 644 1145 715 636 000 60100 A Revise/graft cyclid lining 822 NA 819 044 000 60110 A Revise/graft cyclid lining 822 NA 819 040 000 60110 A Revise/graft cyclid lining 822 NA 819 040 000 60110 A Revise/graft cyclid lining 825 NA 819 040 000 60110 A Revise cyclid lining 825 NA 824 045 000 60110 A Revise cyclid lining 825 NA 824 045 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Revise cyclid lining 841 NA 820 000 000 60110 A Removal (rear gland 1124) NA 1246 065 000 6010 60110 A Removal (rear gland lining 1124) NA 1240 000 000 60110 A Removal (rear gland lining 1124) NA 1240 000 000 60110 A Remova (rear gland lining 1124) NA 1240 000 000 60110 A Remove the gland lision 1138 NA 1177 012 000 000 60110 A Remove the gland lision 1138 NA 1177 012 000 000 60110 A Remove the gland lision 1138 NA 1180 000 000 60110 A Remove the gland lision 1138 NA 1180 000 000 000 60110 A Remove the gland lision 1138 NA 1180 000 000 000 60110 A Remove the gland lision 1138 NA 1180 000 000 000 60110 A Remove the gland lision 1138 NA 1180 000 000 000 000 000 000 000 000 00	68135		4	Remove eyelid lining lesion	1.86	2.12	1.99	60:0	010	69020		A I	Drain outer ear canal lesion	1.50	4,43	2.17	0.10	0
A Revise/graft eyelid lining 644 1145 716 036 090 09101 A Revise/graft eyelid lining 8.43 NA 8.19 0.44 090 09110 A Revise/graft eyelid lining 8.25 NA 8.86 0.61 090 09140 A Revise/graft eyelid lining 8.25 NA 8.87 0.04 0.90 09140 A Revise/graft eyelid lining 8.25 NA 8.87 0.04 0.90 09140 A Revise eyelid lining 8.25 NA 8.74 0.45 0.90 09145 A Revise eyelid lining 8.25 NA 8.74 0.45 0.90 09155 A Revise eyelid lining 8.41 NA 8.24 0.45 0.90 09155 A Revise eyelid lining 8.41 NA 8.24 0.45 0.90 09155 A Revise eyelid lining 8.41 NA 8.24 0.04 0.90 09150 A Revise eyelid lining 8.41 NA 8.24 0.04 0.90 0.00 0.00 A Revise eyelid lining 8.41 NA 8.24 0.05 0.01 0.00 0.00 0.00 0.00 A Revise eyelid lining 8.41 NA 8.24 0.05 0.01 0.00	68200		<	Treat eyelid by injection	0.49	0.59	0.42	0.02	000	00169		A	siopsy of external ear	0.81	1.72	0.48	0.05	0
A Revise/graft cyclid lining 843 NA 831 049 090 0910 A Revise/graft cyclid lining 822 NA 836 061 090 090 09145 A Revise cyclid lining 822 NA 886 061 090 090 09145 A Revise cyclid lining 826 037 050 032 090 09185 A Revise cyclid lining 846 826 527 025 090 090 09185 A Revise cyclid lining 841 NA 824 090 090 09185 A Revise cyclid lining 841 NA 824 090 090 09185 A Revise cyclid lining 841 NA 827 025 020 090 09205 A Harvest eye tissue, alograft 9407 NA 827 023 090 09205 A Harvest eye tissue, alograft 9407 NA 820 023 010 090 09205 A Harvest eye tissue, alograft 9407 NA 820 020 090 090 09205 A Harvest eye tissue, alograft 9407 NA 820 020 010 090 09205 A Harvest eye tissue, alograft 9407 NA 820 020 090 090 09200 A Harvest eye tissue, alograft 9400 NA 820 020 090 090 09200 A Harvest eye tissue, alograft 9400 NA 820 000 000 000 000 090 0900 0900 A Harvest eye tissue, alograft 9400 NA 820 000 000 090 0900 0900 0900 A Harvest eye tissue, alograft 9400 NA 820 000 000 000 0900 0900 0900 0900 090	68320		٧	Revise/graft eyelid lining	6.44	11,45	7.16	0.36	060	69105		A	Siopsy of external ear canal	0.85	2.73	0.82	0.05	0
A Revisegraft eyelid lining	68325		: ∢	Revise/graft evelid lining	8.43	N.	8.31	0,49	060	69110		Ā	temove external ear, partial	3.47	8.04	4.79	0.40	0
A Revisegraft eyelid liming 9.25 NA 8.86 0.61 090 691445 A Revisegraft eyelid liming 5.63 9.37 6.05 0.32 090 69145 A Revise eyelid liming 8.25 3.27 0.25 090 69150 A Revise eyelid liming 8.44 8.62 5.27 0.29 090 69105 A Revise eyelid liming 8.41 8.73 0.23 0.90 69205 A Revise eyelid liming 8.41 8.73 0.23 0.90 69205 C Eyelid liming sugand 1.71 1.71 1.66 0.00 0.	92189		< <	Revise/graft evelid lining	8.22	NA V	8.19	0.44	060	69120		A	temoval of external ear	4.08	Ν	6.25	0.43	0
A Revise eyelid lining 5.63 9.37 6.05 0.90 69145 A Separate eyelid lining 8.26 9.37 6.05 0.90 69156 A Revise eyelid lining 8.24 8.24 0.45 0.90 69156 A Revise eyelid lining 8.41 5.37 0.03 0.09 69210 A Harvest eye lisuse, alogath 4.97 NA 8.24 0.43 0.90 69210 C Eyelid lining surgery 0.00 0.00 0.00 0.00 0.77 69210 A Incisedrant near gland 1.71 1.56 0.05 0.01 69300 A Incisedrant near gland 1.24 NA 1.24 0.00 0.00 0.00 69300 A Incisedrant near gland 1.24 NA 1.23 0.05 0.00 69300 A Removel of rear gland 1.24 NA 1.23 0.05 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	68328		٠.	Revise/graft evelid lining	9.25	N N	8.86	19'0	060	69140		Α.	temove ear canal lesion(s)	8.03	Ϋ́Z	14.42	0.78	0
A Revise/graft eyelid lining 8.26 NA 8.24 0.04 090 69153 A Revise eyelid lining 4.34 8.62 5.27 0.25 000 69153 A Revise eyelid lining 8.14 NA 8.23 0.03 000 69200 A Harveste eyelid lining 8.41 NA 8.20 0.23 000 69200 A Harveste eyelid lining 8.41 NA 8.20 0.23 010 69200 A Harveste eyelid lining 8.41 NA 8.20 0.03 010 69200 A Inciscorban tear gland 1.71 5.17 1.66 0.08 010 69202 A Inciscorban tear gland 1.24 NA 1.23 0.02 0.09 69310 A Removal of tear gland 1.24 NA 1.23 0.05 0.00 6940 A Removal of tear gland 1.24 NA 1.23 0.00 0.0	68130		; ∢	Revise evelid lining	5.63	9.37	6.05	0.32	060	69145			temove car canal lesion(s)	2.65	7,41	3.76	0.26	0
A Revise eyelid lining 8,144 8,62 5,17 0,25 090 69155 A Revise eyelid lining 5,14 8,14 5,38 0,23 090 69205 A Harvest eyelid lining 5,14 8,14 5,38 0,23 0,00 090 69205 C Eyelid lining surgary 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,	31189		: 4	Revise/graft evelid lining	8.26	Z	8.24	0.45	060	69150		_	Extensive ear canal surgery	13.49	Y.	13.51	1.47	0
A Revise eyeficd lining 8.41 NA 8.27 0.49 090 69205 A Harvest eyeficd lining 8.41 NA 8.77 0.44 090 69205 C Eyeild lining surgery 0.00 0.00 0.00 0.00 YYY 69220 A Incise/drain tear gland 1.71 5.17 1.66 0.08 0.00 0.00 0.922 A Incise/drain tear gland 1.71 5.17 1.66 0.08 0.00 0.00 0.00 0.00 0.00 0.00 0	68340		: <	Separate evelid adhesions	4.84	8.62	5.27	0.25	060	69155		_	xtensive ear/neck surgery	23.06	NA	20.32	2.25	0
A Revise eyeitd lining 8.41 NA 8.27 0.44 090 69205 C Eyeitd lining surgery 0.00 0.00 0.03 YYY 69210 C Eyeitd lining surgery 0.00 0.00 0.00 YYY 69220 A Incise/drain tear stac 1.71 5.17 1.66 0.08 0.10 69220 A Incise/drain tear stac 0.96 1.24 NA 12.36 0.05 0.09 69310 A Removal of tear gland 11.24 NA 12.36 0.05 0.09 69310 A Removal of tear stac 8.58 NA 12.31 0.05 0.09 69400 A Removal of fear sac 8.58 NA 12.31 0.05 0.00 69410 A Remove tear gland lesion 11.33 NA 12.30 0.05 0.00 69420 A Remove tear gland lesion 11.33 NA 12.30 0.00 0.00 0.00 0.00 69420 A Clearance of tear and uct opening 1.35 <td< td=""><td>68360</td><td></td><td></td><td>Revise evelid lining</td><td>5.04</td><td>8.14</td><td>5.38</td><td>0.28</td><td>060</td><td>69200</td><td></td><td>Ĭ</td><td>Dear outer ear canal</td><td>0.77</td><td>2.37</td><td>0.73</td><td>0.05</td><td>0</td></td<>	68360			Revise evelid lining	5.04	8.14	5.38	0.28	060	69200		Ĭ	Dear outer ear canal	0.77	2.37	0.73	0.05	0
A Harvest eye tissue, alografh 4.97 NA 5.50 0.23 010 69210 C Eyeid lining surgery 0.00 0.00 NYY 69220 A Incise/drain tear gland 1.37 1.60 0.00 0.00 6920 A Incise/drain tear gland 1.24 NA 1.236 0.65 0.00 6930 A Removal of tear gland 1.249 NA 1.236 0.65 0.00 6930 A Partial removal (rear gland 4.60 6.65 3.11 0.23 0.00 69400 A Riopsy of tear gland 4.60 6.65 3.11 0.23 0.00 69400 A Removal of fear gland lesion 11.93 NA 11.77 0.62 0.00 69410 A Remove tear gland lesion 11.93 NA 11.37 0.00 0.00 69410 A Clearance of tear duct ducts 3.67 6.93 3.01 0.13 0.00 69410<	68362		₹	Revise evelid lining	8.4	AN	8.27	0.44	060	69205		-	lear outer ear canal	1.20	NA	1.42	80.0	0
C Eyelid Inling Surgery 0.00 0.00 0.00 YYY 69220 A Incisc/Grain tear gland 1.71 5.17 1.66 0.08 0.00 60.02 0.00 69222 A Incisc/Grain tear gland 1.24 NA 1.25 0.05 0.00 69310 69310 A Removal of rear gland 1.249 NA 12.36 0.65 0.00 69400 69310 A Removal of rear gland 4.60 6.65 3.11 0.25 0.00 69400 69410 A Removal of rear gland 4.20 NA 1.23 0.05 0.00 69400 69410 A Removal of rear gland lesion 11.93 NA 1.23 0.02 0.00 69400 69400 A Remove tear gland lesion 11.93 NA 1.23 0.00 69400 69401 A Reviewer act duct chering 1.98 NA 1.23 0.00 69400 69431 <	68371		. 4	Harvest eve tissue, alografi	4.97	A	5.50	0.23	010	69210			temove impacted ear wax	0.61	0.71	0.26	0.04	0
A Incise/drain rear gland 1.71 5.17 1.66 0.08 010 69222 A Incise/drain rear gland 1.71 5.17 1.66 0.08 010 69310 A Removal of rear gland 0.96 1.24 0.04 0.05 0.00 0.09 0.0310 A Removal of rear gland 12.49 0.04 12.36 0.65 0.00 0.0310 A Removal of rear gland 12.41 0.04 12.31 0.65 0.00 0.00 0.00310 A Removal cear gland 12.41 0.04 0.02 0.00 0.00 0.00 0.00 A Remove tear gland lesion 11.33 0.04 0.01 0.00 0.00 0.00 A Remove tear gland lesion 11.33 0.04 0.01 0.00 0.00 0.00 A Remove tear gland lesion 11.33 0.04 0.01 0.00 0.00 0.00 A Remove tear gland lesion 1.03 0.04 0.00 0.00 0.00 0.00 A Remove tear gland lesion 0.00 0.00 0.00 0.00 0.00 A Remove tear gland lesion 0.00 0.00 0.00 0.00 0.00 A Create tear duct drain 0.00 0.00 0.00 0.00 0.00 A Create tear duct drain 0.00 0.00 0.00 0.00 0.00 0.00 A Create tear duct drain 0.00 0.00 0.00 0.00 0.00 0.00 A Create tear duct drain 0.00 0.	68399		Ü	Evelid lining surgery	00.0	00'0	0.00	0.00	YYY	69220		Ĭ	lean out mastoid cavity	0.83	5.69	0.80	0.05	0
A Incise/drain rear sac 2.32 5.54 2.02 0.12 010 69300 A Incise/drain rear sac 0.96 1.57 1.50 0.05 010 69310 A Removal of rear gland 1.241 NA 1.231 0.65 090 69320 A Partial removal, Lear gland 4.60 6.65 3.11 0.23 000 69400 A Romove car gland lesion 1.241 NA 1.231 0.65 090 69400 A Remove tear gland lesion 1.13 NA 1.231 0.65 090 69400 A Remove tear gland lesion 1.135 NA 1.177 0.62 090 69421 A Remove tear gland lesion 1.135 NA 1.239 1.45 000 69420 A Remove tear gland lesion 1.135 NA 1.239 1.45 000 69421 A Clearance of tear duct drain 9.70 NA 1.23 0.00 090 69431 A Create tear duct drain 9.70 NA	68400		¥	Incise/drain tear gland	1.71	5.17	1.66	80.0	010	69222		Ť	Nean out mastoid cavity	1.42	4.17	2.10	60.0	0
A Removal of rear gland 1.249	68420		٧	Incise/drain tear sac	2.32	5.54	2.02	0.12	010	69300		_	tevise external ear	69.9	11.19	5.81	0.44	>
A Removal of tear gland 12.44	68440		< <	Incise tear duct opening	96.0	1.57	1.50	0.05	010	69310		_	(ebuild outer ear canal	10.85	NA	16.99	1.07	0
A Partial removal, tear gland 12.41 NA 12.31 0.65 000 69399 A Removal offerar sac 8.58 3.11 0.23 000 69400 A Removal offerar sac 4.40 NA 8.70 050 000 69400 A Remova tear gland lesion 11.93 NA 11.77 0.62 000 69420 A Remova tear gland lesion 14.86 NA 12.77 0.62 090 69420 A Remova tear gland lesion 14.86 NA 11.77 0.62 090 69420 A Remova tear gland lesion 14.86 NA 11.77 0.62 090 69420 A Remova tear gland lesion 14.86 NA 11.77 0.62 090 69420 A Remova tear gland lesion 17.67 NA 12.91 0.00 090 69430 A Remova tear duct drain 9.78 NA 9.51 0.05 090 69430 A Create tear duct drain 9.78 NA 9.81 0.05 090 69450 A Create tear duct drain 9.77 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69450 I CPT codes and descriptions only are copyright 2009 Arcticas Medicar payment. The budget neutrality reduction from the cohiopractic demonstration is not reflected in the RVUs for CPT Medicare payment. *Codes 98940, 98941, and 98942. The required reduction will only be reflected in the RIes used for malpractice RVUs made to rounding.	68500		<	Removal of tear gland	12.49	N.	12.36	9.65	060	69320		_	cebuild outer ear canal	17.03	NA	22.47	99'1	0
A Biopsy of fear gland 4.60 6.65 3.11 0.23 000 69400 A Romove tear gland lesion 11.93 NA 12.39 0.00 69405 A Clearance of fear duct 1 3.67 6.93 3.01 0.18 0.10 69405 A Remove tear gland lesion 11.93 NA 11.77 0.62 0.00 69421 A Remove tear gland lesion 11.93 NA 11.77 0.62 0.00 69421 A Repair tear duct gland lesion 2.08 3.78 2.17 0.10 0.10 69435 A Create tear duct drain 9.78 NA 6.11 0.10 0.10 69435 A Create tear duct drain 9.70 NA 10.13 0.56 0.00 69435 A Create tear duct drain 9.70 NA 10.13 0.58 0.00 69435 A Create tear duct drain 9.70 NA 10.13 0.58 0.00 69436 A Create tear duct drain 9.70 NA 10.13 0.58 0.00 69436 A Create tear duct drain 9.70 NA 10.13 0.58 0.00 69436 A Create tear duct drain 9.70 NA 10.13 0.58 0.00 69501 - CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights - Reserved. - If values are reflected for codes oot payable by Medicare, please note that these values have been established as a countant public and are not used for Medicare payment. - The budget mentality reduction from the chiropracte demonstration is not reflected in the RIVUs for CPT - Medicare payment. - Medicare payment. - Codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for malpractice RVUs may not sum due to rounding.	68505		٧	Partial removal, tear gland	12.41	NA	12.31	9.65	060	66366		Ī	Juter ear surgery procedure	0.00	0.00	0.00	00:0	>-
A Removal of Year sac 8.58 NA 8.87 0.50 090 69400 A Remove tear gland lesion 11.93 NA 11.77 0.62 090 69420 A Remove tear gland lesion 11.93 NA 11.77 0.62 090 69420 A Remove tear gland lesion 14.86 NA 12.39 1.45 090 69421 A Repair tear duct decision 14.87 NA 12.39 1.45 090 69431 A Create tear and tot opening 2.08 3.78 2.17 0.10 010 69430 A Create tear duct drain 9.78 NA 9.58 090 69440 A Create tear duct drain 9.78 NA 9.58 090 69450 A Create tear duct drain 9.78 NA 10.13 0.58 090 69501 - CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. - If values are reflected for codes oot payable by Medicare, please note that these values have been established as a contrast public dark of moderate payment. - The budget neutrality reduction from the chiropractic demonstration is not reflected in the Ries used for Medicare payment. - The budget neutrality reduction from the chiropractic demonstration is not reflected in the Ries used for malpractice RVUs may not sum due to rounding. - Codes 98940, 98941, and 98942. The required reduction will only be reflected in the Ries used for malpractice RVUs may not sum due to rounding.	68510		٧	Biopsy of tear gland	4.60	9.65	3.11	0.23	000	69400		A L	nflate middle ear canal	0.83	2.94	0.80	0.05	0
A Biopsy of fear sac 442 NA 2.62 0.22 000 69405 A Clearance of tear duct 3.57 6.93 3.01 0.18 010 69420 A Remove tear gland lesion 1.33 NA 11.77 0.62 000 69421 A Remove tear gland lesion 1.486 NA 12.39 1.45 000 69421 A Remove tear duct opening 7.08 3.78 2.17 0.10 010 69435 A Create tear duct opening 9.78 NA 9.51 0.56 090 69436 A Create tear duct drain 9.78 NA 9.51 0.56 090 69436 A Create tear duct drain 9.78 NA 9.51 0.56 090 69436 A Create tear duct drain 9.78 NA 9.51 0.56 090 69436 A Create tear duct drain 9.78 NA 10.13 0.58 090 69436 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. The budget neutrality reduction from the chiroparatic demonstration is not reflected in the RVUs for CPT codes 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT codes 98940, 98941. The required reduction will only be reflected in the RVUs for CPT codes 98940, 198942. The required reduction will only be reflected in the RVUs for CPT codes 98940, 1036 for malpractice RVUs may not sum due to rounding.	68520		4	Removal of tear sac	8.58	NA	8.87	0.50	060	69401		۲ آ	nflate middle ear canal	0.63	1.60	99.0	0.04	0
A Remove tear gland lesion 11.93 NA 11.77 0.62 090 69421 A Remove tear gland lesion 11.93 NA 11.77 0.62 090 69421 A Remove tear gland lesion 11.93 NA 11.77 0.62 090 69424 A Remove tear gland lesion 11.93 NA 12.99 1.45 090 69424 A Repair tear duct ducts A Repair tear duct opening 2.08 3.78 2.17 0.10 010 69436 A Create tear duct drain 9.78 NA 9.68 0.50 090 69440 A Create tear duct drain 9.77 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69450 I CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. I If values are reflected for codes on payable by Medicare, please note that these values have been established as a courresty to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT odds 98940, 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT demonstration is not reflected in the RVUs for CPT odds 98940, 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT odds 98940, 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT odds 98940, 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT odds 98040, 98040, 98041, and 98042. The required reduction will only be reflected in the RVUs for CPT odds 98040, 9	68525		4	Biopsy of tear sac	4.42	NA	2.62	0.22	000	69405		V	atheterize middle ear canal	2.65	80.4	2.36	0.17	0 0
A Remove tear gland lesion 11.93 NA 11.77 0.62 0.90 69421 A Remove tear gland lesion 11.93 NA 11.77 0.62 0.90 69424 A Repair tear ducts 1.67 NA 7.68 0.43 0.90 69435 A Repair tear duct opening 2.08 3.78 2.17 0.10 0.10 69436 A Create tear act duct drain 9.78 NA 9.31 0.56 0.90 69436 A Create tear duct drain 9.70 NA 10.13 0.58 0.90 69450 A Create tear duct drain 9.77 NA 10.13 0.58 0.90 69450 CPT codes and descriptions only are copyright 2009 Ancrica an Medical Association. All Rights Reserved. I I values are reflected for codes only payable by Medicare, please note that these values have been established as a conversal polyment and ear on used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT Medicare payment. Global tools for malpractice RVUs may not sum due to rounding. Global tools for malpractice RVUs may not sum due to rounding.	68530		V	Clearance of tear duct	3.67	6.93	3.01	81.0	010	69420		V	acision of eardrum	1.35	3.52	1.75	0.09	٠,
A Remove tear gland lesion 1486 NA 12.39 145 090 69434 A Repair tear ducts A Repair tear ducts A Create tear duct opening A Create tear duct drain 9.78 NA 9.58 0.50 090 69440 A Create tear duct drain 9.78 NA 9.68 0.50 090 69450 A Create tear duct drain 9.78 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69501 - CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 1 If values are reflected for codes oot payable by Medicare, please nore that these values have been established as a courtest purple by Medicare, please nore that these values have been schooling trade of the properties of properties	68540		٧	Remove tear gland lesion	11.93	NA	11.77	0.62	060	69421		Α.	ncision of eardrum	1.75	NA.	2.10	0.11	0 (
A Repair tear ducis A Revise tear duct opening A Create tear duct drain B C Create tear duct drain A Create tear duct drain B C Create tear duct drain	68550		∢	Remove tear gland lesion	14.86	Y X	12.39	1.45	060	69424		Α,	temove ventilating tube	0.85	4.	6/70	0.06	<i>-</i>
A Revise tear duct opening 2.08 3.78 2.17 0.10 010 06450 A Create tear addain 9.78 NA 9.68 0.56 090 69440 A Create tear duct drain 9.70 NA 9.68 0.50 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69450 A Create tear duct drain 9.87 NA 10.13 0.58 090 69501 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. I CPT codes so onresty to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT Medicare payment. Medicare payment. Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.	68700		A	Repair tear ducts	1.67	NA.	7.68	0.43	060	69433		۷٠	reate eardrum opening	.54	3.54	. se.	0.10	
A Create tear as drain 9.78 NA 9.51 0.56 090 09440 A Create tear duct drain 9.78 NA 9.68 0.50 090 69450 A Create tear duct drain 9.70 NA 10.13 0.58 090 69501 A Create tear duct drain 9.87 NA 10.13 0.58 090 69501 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. I f values are reflected for codes only payable by Medicare, please note that these values have been established as a courtest public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the RIJes used for malpractice RVUs may not sum due to rounding. Global totals for malpractice RVUs may not sum due to rounding.	68705		¥	Revise tear duct opening	2.08	3.78	2.17	0.10	010	69436		ν.	reate eardrum opening	1.98	V.	2.18	0.13	-
A Create tear duct drain 9.70 NA 9.68 0.50 0.00 69450 A Create tear duct drain 9.87 NA 10.13 0.58 0.90 6.9501 A Close tear duct opening 1.75 3.22 1.96 0.08 0.10 6.9502 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. If values are reflected for codes on payable by Medicart places on that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. Are done to be appreciate the properties of the production of the product	68720		A	Create tear sac drain	9.78	Y.	9.51	0.56	060	69440		Α.	exploration of middle ear	7.62	V Z	10.20	4.74	•
A Create tear duct (dain 9.87 NA 10.13 0.58 0.90 09501 A Close tear duct opening 1.5 3.22 1.96 0.08 010 69502 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. If values are reflected for codes on payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.	68745		¥	Create tear duct drain	9.70	×;	89.6	0.50	060	69450		₩,	ardrum revision	5.61	Y ?	8.42	0.55	D
A Close tear duct opening 1.75 3.22 1.96 0.08 010 69502 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. If values are reflected for codes on payable by Medicare, please note that these values have been established as a countesty to the general public and are not used for Medicare payaent. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the RVUs for CPT Medicare payment. Global totals for malpractice RVUs may not sum due to rounding.	68750		¥	Create tear duct drain	78.6	ď,	10.13	0.58	060	10560		ζ.	лазіоіфестопту	7.17	K.	3.91	69.0	2 (
itical Association. All Rights for that these values have been edicare payment. is not reflected in the RVUs for CPT reflected in the files used for	68760		٧	Close tear duct opening	1.75	3.22	96.1	80:0	010			~ ~	Aastoidectomy	12.44	Y Z	12.71	1.27	0
te that these values have been cleare payment. of is not reflected in the RVUs for CPT ireflected in the files used for		· CPT c	odes and	d descriptions only are copyright 2009 At.	nerican Medi	ical Associat	ion. All Rig	hts		-	CPT cod	es and de	scriptions only are copyright 2009 Ame	erican Medi	cal Associati	on. All Rigl	ıts	
the transmisser agreement of the transmisser of the		Reserve	ed.	and the second s	al constant	that those	d branch saule.	100		æ.7	eserved.	are reflec	ted for codes not namely by Madicare	a please not	that theen v	d eved sente	uod	
is not reflected in the RVUs for CPT reflected in the files used for		erablish	hed as a r	courses to the general public and are not	re, picase non t used for Me	dicare navm	ent.	133		, A	stablished	as a cou	resy to the general public and are not	used for Me	dicare payme	andes anne e	3	
ובשיכינת חודי וויס מסכים וסו		The bu	udget net	utrality reduction from the chiropractic de	emonstration	is not reflect	ted in the RV	*Us for CPT		3.	The budg	et neutra	lity reduction from the chiropractic den	monstration	is not reflect	ed in the RV	Us for CPT	
astractice RVUs may not sum due to rounding.		Medicar	re payme	ent.		i circotta m	ac mics asse	š		₹ ≥	fedicare 1	ayment.	and soften the requiremental in	and free out	n m pagania	and the same	2	
		4 Global	I totals fc	or malpractice RVUs may not sum due to	rounding.					4	Global to	tals for m	alpractice RVUs may not sum due to r	rounding.				

7 34	2.68	900		2 9	0.84	3.1	‡ 5	22	<u>-</u>	0.54	66	1.36	35	2 9	3 9	9 %	35	14	. 00	58	<u>×</u> 9	3 -	. 60	2	80	5 8	3 =)1	0.00	0.01	0.00	7	10.0	0.00	0.01	0.02	9 5	02			or CPT
y Mak- Practice	•		: -				7 1.4			_														0.00		10.0											σō è	, 0	Rights	ave been	ne RVUs fi used for
Facility PE RVUs ^{2,1}	21.90	1441	15.50	000	10.85	13.75	12.97	12.13	1.84	14.44	12.70	17.78	14.33	100	10.46	22.75	21.40	24.14	0.00	1.62	ς <u>ς</u>	AN 0	S Z	Z	0.38	₹ ₹ Z Z	0.05	Ϋ́	YZ .	0.03 AN	X Z	0.08	NA	Y.	0.07	K :	Ϋ́,	0.11	iation. Al	e values ha	ected in th n the files
Non- Facility PE RVUs ^{2,3}	Z Z	ž Z	Y N	200	Z	NA	Ν	ΥN	K Z	YZ ;	Y:	Y Z	K Z	4 6	9.0 V	Z Z	. Y	Y.	0.00	YY.	2.48	21.7	2.64	2.26	0.38	0.54	0.05	0.59	0.54	0.05	0.64	0.08	97.0	69.0	0.07	1.08	0.97	- - - - - -	dical Assoc	te that thes ledicare pay	n is not refl reflected i
Physi- cian Work RVUs ^{2,3}	27.44	81 91	10.13	000	8 61	13.39	14.55	12.52	10.40	10.32	11.15	13.80	0971	00.71	0.00	20.73	29.22	32.21	00'0	3.46	1.19	0.00	61.1	0.00	1.19	0.17	0.17	0.18	0.00	0.18	0.00	0.25	0.18	0.00	0.18	0.34	0.00	0.34	American Me	care, please no	demonstrations will only be
Daacriotion	Dolosco facial name	Dennir Good name	Description facial nerve	Nepall latial little	Incise inner ear	Incise inner ear	Explore inner ear	Explore inner ear	Establish inner car window	Revise inner ear window	Remove inner ear	Remove inner ear & mastoid	Incise uner ear nerve	Implant coeniear nevice	inner ear surgery procedure	Incise unior car noive Release facial nerve	Release inner ear canal	Remove inner ear lesion	Temporal bone surgery	Microsurgery add-on	Contrast x-ray of brain	X-ray eye for foreign body	X-ray eye for foreign body	X-ray exam of jaw	X-ray exam of jaw	X-ray exam of jaw	X-ray exam of iaw	X-ray exam of jaw	X-ray exam of mastoids	X-ray exam of mastoids	X-ray exam of mastoids	X-ray exam of mastoids	X-ray exam of mastoids	X-ray exam of mastoids	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	reserver. If yaluse are reflected for codes not payable by Medicare, please note that these values have been If yaluse are reflected for codes not payable and are not used for Medicare payment.	The budget neurality reduction from the chtropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for				
States	orange V	< -	٠ -	<i>د</i> ر	۶ (. ∢	∢	¥	٧	∢	∢ ·	∢ •	< ⊲	د (, د	€ 4	: <	Ą	၀	×	۷.	< <	< <	. ≺	Ą	∢ <	< 4	V	4	< <	< <	*	Ą	4	Ą	۷.	Y	¥	odes and	es are re hed as a (The budget neutracedes 98940, 9894
20	ē																				ç	2 %	07	TC	56	7.	2 9		IC	56	TC	26		ЛC	56	1	5	56	CPT	2 If values establishe	The bi
CPT ^{1,3} /	60776	60740	09740	007.09	10809	69802	69805	90869	69820	69840	90669	01669	69915	06660	69669	06660	09669	02669	62669	06669	70010	0000	70015	70015	70015	70030	70030	70100	70100	70100	70110	70110	70120	70120	70120	70130	70130	70130			
industrial in	000	060	060	060	010	060	060	060	060	060	060	060	060	ara	060	060	060	060	060	060	060	260	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060			F
Mal- Practice	FL	17.	1.52	16.1	800	1.08	1.92	3.48	1.30	1.33	1.37	1.37	181	67.0	0.58	1.50	20	1.32	1.49	1.49	1.26	6.2	75.1	1.63	1.78	0.95	151	1.52	96'0	0.96	0.03	0.81	1.02	1.40	1.83	1.49	1.86	1.59	ights	: been	₹VUs for CP ed for
Facility PE PVII.e.2.3	17.00	96.71	10.28	27.70	20.17	15.81	21.15	28.81	13.92	14.70	18.51	14.90	21.91	5.21	6.67	12.93	14.83	18.06	20.38	20.18	14.27	06.71	21.10	20.97	21.77	11.18	15.50	14.67	11.17	11.17	11.96	9.52	11.89	13.71	15.98	14,20	16.10	15.95	ation. All R	values have ment.	ected in the I the files us
Non- Facility PE PVIIs ^{2,3}	80 X	Ž.	K .	ζ ×	V .	N AN	NA	NA	NA	NA	AN	Y ;	NA S	5.54	2.5	₹ ₹	Z Z	Z	NA	NA	Y.	Z Z	K Z	Š	NA	Y X	K Z	Z V	NA	Y Z	(4 (Z	X X	NA	NA	ΥN	NA	ΝA	K Z	dical Associ	ote that these fedicare pay	n is not refle reflected in
Physi- cian Work	MVUS-	13.03	13.58	20.24	1771	10	19.69	35.71	13.31	13.64	14.08	14.08	18.55	4.4	5.94	9.93	12.92	13.39	15.29	15.18	12.77	16.91	17.00	16.57	18.23	9.71	15.80	15.49	6.80	9.81	70.11	8.28	10.50	14.31	18.80	15.29	19.05	14.57	American Me	care, please n not used for N	demonstratic on will only b
					b.												• "	,	S	es	toid	piote	Bioid	astoid	stoid	•			res	res			773	imul	ulat	ion	_		1 2009	Medi id are	opractic reductic
Passachtellan	Description	Kemove masioid structures	Extensive mastoid surgery	Extensive mastord surgery	Remove part of temporar cone	Remove ear lesion	Remove ear lesion	Remove ear lesion	Mastoid surgery revision	Mastoid surgery revision	Mastoid surgery revision	Mastoid surgery revision	Mastoid surgery revision	Repair of eardrum	Repair of eardrum	Repair cardrum structures	Rebuild eardnim structures	Renair eardrum structures	Rebuild cardrum structures	Rebuild eardrum structures	Revise middle ear & mastoid	Revise middle car & mastoid	Revise middle ear & mastoid	Revise middle ear & mastoid	Revise middle car & mastoid	Release middle ear bone	Kevise middle car bone	Revise middle car bone	Repair middle ear structures	Repair middle ear structures	Remove masion air ceus	Close mastoid fistula	Remove/repair hearing aid	Implant temple bone w/stimul	Temple bne implnt w/stimulat	Temple bone implant revision	Revise temple bone implant	Release facial nerve	descriptions only are copyrigh	lected for codes not payable by purtesy to the general public at	trality reduction from the chir 41, and 98942. The required
	*						A Remove ear lesion								A Repair of eardrum		A Rebuild earthum structures	, –					A Revise middle ear & ma				A Kevise middle ear bone	A Revise middle car bone	A Repair middle ear structu	A Repair middle ear structu	A Kemove masioid air ceus	A Close mastoid fistula		A Implant temple bone w/st	A Temple bne implut w/stim	A Temple bone implant revis	 A Revise temple bone implan 	A Release facial nerve	odes and descriptions only are copyrigh	d. es are reflected for codes not payable by ted as a courtesy to the general public ar	idget neutrality reduction from the chir 3940, 98941, and 98942. The required
1 1 1 2	_																	, –												A Repair middle ear structu	A Remove middle est nerve			_				A Release facial nerve	' CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. 1 Ivalues are reflected for codes not payable by Medicare, please note that these values have been established as a contesy to the general public and are not used for Medicare payment.	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for

(Frechit				clan	Facility	Facility	Mal-		(c).100				cian	Facility	Facility	Mai-	
HCPCS	Mod	Status	Description	RVUs ^{2,3}	RVUs ^{2,3}	RVUs23	RVUs ^{23,4}	Globai	HCPCS	Mod	Status	Description	RVUs.23	RVUs ^{2,3}	RVUs,	RVUs ^{2,3,4}	Global
70134		¥	X-ray exam of middle ear	0.34	0.81	Ϋ́	0.02	XXX	70320		_	Full mouth x-ray of teeth	0.22	1.03	Z V	0.01	X
70134	C	ď	X-ray exam of middle ear	0.00	0.70	NA	0.00	XXX	70320	TC	_	Full mouth x-ray of teeth	0.00	0.93	NA AN	0.00	XXX
70134	56	¥	X-ray exam of middle ear	0.34	0.10	0.10	0.02	XXX	70320	56	_	Full mouth x-ray of teeth	0.22	0.10	0.10	10.0	XX
70140		∢	X-ray exam of facial bones	0.19	0.49	Ν	10.0	XXX	70328			X-ray exam of jaw joint	0.18	0.59	Y.	10.0	XXX
70140	C	¥	X-ray exam of facial bones	0.00	4.0	Ν	0.00	XXX	70328	TC		X-ray exam of jaw joint	0.00	0.53	NA	00'0	XXX
70140	26	K	X-ray exam of facial bones	0.19	0.05	0.05	10.0	XXX	70328	26	, ,	X-ray exam of jaw joint	91.0	90:0	90.0	0.01	XXX
70150		4	X-ray exam of facial bones	0.26	0.76	N V	0.02	XXX	70330		۲ ۷	X-ray exam of jaw joints	0.24	96.0	ΝA	10.0	XXX
70150	IC	∢	X-ray exam of facial bones	0.00	69.0	Ϋ́	0.00	XXX	70330	TC	^ لا	X-ray exam of jaw joints	0.00	98.0	ΑN	0.00	XXX
70150	56	¥	X-ray exam of facial bones	0.26	0.07	0.07	0.02	XXX	70330	26	` *	X-ray exam of jaw joints	0.24	60'0	60:0	10.0	XXX
70160		4	X-ray exam of nasal bones	0.17	0.63	Ν	0.01	XXX	70332		Y Y	X-ray exam of jaw joint	0.54	4.	۲Z	0.01	XXX
0910/	TC	K	X-ray exam of nasal bones	0.00	0.58	NA	0.00	XXX	70332	TC	۲ ۲	X-ray exam of jaw joint	00.0	1.24	۲X	0.00	XXX
09102	56	∢	X-ray exam of nasal bones	0.17	0.05	0.05	10.0	XXX	70332	56	۲ ۲	X-ray exam of jaw joint	0.54	0.20	0.20	10:0	XXX
70170		O	X-ray exam of tear duct	0.00	NA	Ν	0.00	XXX	70336		٧ ۲	Magnetic image, jaw joint	1.48	6.64	Ϋ́Z	0.11	XXX
70170	TC	O	X-ray exam of tear duct	00.00	Z.	NA	0.00	XXX	70336	JC	V	Magnetic image, jaw joint	00.0	6.19	N.	0.00	XXX
70170	56	4	X-ray exam of tear duct	0.30	0.09	0.09	0.02	XXX	70336	26	Ą	Magnetic image, jaw joint	1,48	0.45	0.45	0.10	XXX
70190		4	X-ray exam of eye sockets	0.21	0.64	Ϋ́	0.02	XXX	70350		٠ ٧	X-ray head for orthodontia	0.17	0.36	ΥN	00:00	XX
70190	JC	٧	X-ray exam of eye sockets	0.00	0.58	Ϋ́	0.00	XXX		TC	Α,	X-ray head for orthodontia	0.00	0.26	ΥZ	00.00	XXX
70190	26	<	X-ray exam of eye sockets	0.21	90.0	90.0	0.02	XXX		26	A 7	X-ray head for orthodontia	0.17	60.0	0.09	000	XXX
70200		₹	X-ray exam of eye sockets	0.28	0.78	Y.Z	0.02	XXX			· •	Panoramic x-ray of taws	0.20	0.30	YZ.	0.01	XXX
70200	7	: 4	X-ray exam of eye cockets	000	0.70	Z	000	XXX	70355	J.	: ∡	Panoramic v-ray of jaws	900	0.21	A Z	000	XXX
00000	2 %	: <	V. ray avam of one cockets	3.00	000	300	0.03	XXX	70355	, 2	: 4	Pancramic variation	0.20	000	000	50:0	XXX
70200	7	۲.	A-1dy chain of cyc suchels	07:0	0.00	0.00	70.0	XXX	0000	07		anoraniic A-tay of Jaws	0.20	5.6	6.00	0.0	552
/0710	-	∢ .	X-ray exam of sinuses	0.17	0.00	ď;	0.01	XXX		9	ζ.	A-ray exam of neck	0.17	0.52	ď.	0.01	χ.
70210	ပ္	V	X-ray exam of sinuses	0.00	0.54	V Z	0.00	XXX	70360	ည	<u>ر</u>	X-ray exam of neck	0.00	0.46	۷ Z	0.00	XXX
70210	56	∢	X-ray exam of sinuses	0.17	90.0	90.0	0.01	XXX	70360	56	A A	X-ray exam of neck	0.17	0.05	0.05	0.01	XX
70220		A	X-ray exam of sinuses	0.25	0.72	ΑN	0.01	XXX			A	Throat x-ray & fluoroscopy	0.32	1.80	٧Z	0.02	XXX
70220	IC	∢	X-ray exam of sinuses	0.00	0.63	NA	0.00	XXX	70370	TC	Α	Throat x-ray & fluoroscopy	00'0	1.69	ΑN	00.0	XXX
70220	76	V	X-ray exam of sinuses	0.25	0.08	0.08	10.0	XXX		26	Α.	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.02	XXX
70240		Æ	X-ray exam, pituitary saddle	61.0	0.53	ΝA	0.01	XXX	10371		¥	Speech evaluation, complex	0.84	1.51	A'N	0.04	XXX
70240	JC	<	X-ray exam, pituitary saddle	0.00	0.47	NA	0.00	XXX	70371	TC 1	۶, د	Speech evaluation, complex	000	1.21	Y.	00:00	XXX
70240	26	∢	X-ray exam, pituitary saddle	0.19	90.0	90.0	0.01	XXX	70371	26	A S	Speech evaluation, complex	0.84	0.30	0.30	0.04	XXX
70250		A	X-ray exam of skull	0.24	0.62	Ν	0.02	XXX	70373		ν	Contrast x-ray of larynx	0.44	1.67	V.V.	0.02	XXX
70250	TC	٧	X-ray exam of skull	0.00	0.56	ΝA	0.00	XXX		TC	Α (Contrast x-ray of larytax	0.00	1.52	NA	0.00	XXX
70250	56	Ą	X-ray exam of skull	0.24	90:0	90.0	0.02	XXX	70373	56	V V	Contrast x-ray of larynx	44.0	91.0	91.0	0.02	XXX
70260		Ą	X-ray exam of skull	0.34	0.78	Ν	0.02	XXX	70380		۸ ۷	X-ray exam of salivary gland	0.17	6.79	A'N	10.0	XXX
70260	C	¥	X-ray exam of skull	00'0	69.0	NA	0.00	XXX		7C	^ لا	X-ray exam of salivary gland	00.00	0.71	NA V	00:0	XXX
70260	56	ď	X-ray exam of skull	0.34	60.0	60.0	0.02	XXX	70380	26	۷ ۷	X-ray exam of salivary gland	0.17	80.0	80.0	00.0	XXX
70300		٧	X-ray exam of teeth	0.10	0.24	ΥZ	0.00	XXX	70390		Α ,	X-ray exam of salivary duct	0.38	2.09	NA	0.03	XXX
70300	TC	∢	X-ray exam of teeth	0.00	0.19	NA	000	XXX	70390	TC	^ V	X-ray exam of salivary duct	00'0	1.97	KZ	00:0	XXX
70300	56	4	X-ray exam of teeth	0.10	0.05	0.05	0.00	XXX	70390	26	A A	X-ray exam of salivary duct	0.38	0.12	0.12	0.03	XXX
70310		<	X-ray exam of teeth	0.16	0.81	Ν	000	XXX	70450		Α (Ot head/brain w/o dye	0.85	2.87	Y.Z	90'0	XXX
70310	TC	∢	X-ray exam of teeth	0.00	0.72	NA	0.00	XXX	70450	77	A (Ct head/brain w/o dye	00.0	2.61	Y.	00:0	XXX
70310	26	A	X-ray exam of teeth	0.16	60:0	0.09	0.00	XXX	70450	56	A (Ct head/brain w/o dye	0.85	0.26	0.26	90.0	XXX
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	Reserved.	eq.							2.	Reserved.							
	2 If valu	ues are re	² If values are reflected for codes not payable by Medicare, please note that	re, please not	e that these	these values have been	peen		Ι,	f values	are reflec	If values are reflected for codes not payable by Medicare, please note that these values have been	e, please not	e that these va	alues have be	cn .	
	establis	sped as a c	established as a courtesy to the general public and are not used for Medicare	t used for Me	dicare payment	ient.			55	tablished	as a con	sstablished as a courtesy to the general public and are not used for Medicare payment	used for Me	dicare payme	int.	,	
	The b	nadget neu	The budget neutrality reduction from the chiropractic demonstration is not	emonstration	is not reflec	ted in the R	reflected in the RVUs for CPT			The budg	et neutra	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	monstration	is not reflect	ed in the RV	Js for CPT	
	codes	98940, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	the files use	d for		3 2	des 989	0, 98941	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be 1	reflected in tr	e files used	.o.	
	Medic	Medicare payment.	ent.	9					Υ.	Medicare payment	аушевт.	The state of the s					
	Clops	al totals to	Global totals for malpractice RVUs may not sum due to rounding,	o rounding.					,	Global to	tals tor m	Global totals for majpractice RVUs may not sum due to rounding,	rounding.				

CPT ^{1,3} /				Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice		CPT ^{1,3}				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	1
HCPCS	Mod	Startus	Description	RVUs-	RVUs".	KVUs.	#WG8	Global	70547	00	Status A	Mri orhit/face/neck w/dve	162	8.50	S X	0.12	XXX
70460	Ç	₹ •	Ct nead orani w/dye	C7.0	3.44	(4	0.00	XXX	70542	Ţ	: 4	Mri orbit/face/neck w/dve	000	8.00	X	00.0	XXX
70460	۷ بر	(<	Ct head brain w/dve	2 -	0.35	0.35	0.07	XXX	70542	50	< <	Mri orbit/face/neck w/dye	1.62	0.50	0.50	0.11	XXX
70470	2	< <	Ct head/brain w/o & w/dve	1.27	4.62	Ν	0.09	XXX	70543		ď	Mri orbufac/nck w/o & w/dye	2,15	10.37	NA	0.16	XXX
70470	ıc	<	Ct head/brain w/o & w/dye	0.00	4.23	AN.	0.00	xxx	70543	1C	٧	Mri orbt/fac/nck w/o & w/dye	0.00	9.71	NA	0.01	XXX
70470	26	Ą	Ct head/brain w/o & w/dye	1.27	0.39	0.39	0.08	XXX	70543	56	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.66	9.0	0.15	XX
70480		Ą	Ct orbit/ear/fossa w/o dye	1.28	4.98	N.	80.0	XXX	70544		Ą	Mr angiography head w/o dye	1.20	18.8	Y.	0.09	XXX
70480	TC	Ą	Ct orbit/ear/fossa w/o dye	000	4.57	NA	0.00	XXX	70544	TC	Ą	Mr angiography head w/o dye	0.00	4.	Y.	0.00	X
70480	76	٧	Ct orbit/ear/fossa w/o dye	1.28	0.40	0.40	0.08	XXX	70544	56	Ą	Mr angiography head w/o dye	1.20	0.37	0.37	80.0	XXX
70481		٧	Ct orbit/ear/fossa w/dye	1.38	5.83	NA	0.10	XXX	70545		Ą	Mr angiography head w/dye	1.20	8.8	Y :	0.09	XXX
70481	TC	٧	Ct orbit/ear/fossa w/dye	00:0	5.41	NA	0.00	XXX	70545	Σ	Ą	Mr angiography head w/dye	0.00	44.8	Y .	0.00	XX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.42	0.42	0.09	xxx	70545	56	¥.	Mr angiography bead w/dye	1.20	0.37	0.37	0.08	XX
70482		₹	Ct orbit/ear/fossa w/o&w/dye	1.45	6.59	AN :	0.10	XXX	70546	Ę	∢ •	Mr angrograph head w/o&w/dye	08.1	13.54	K X	0.13	X X
70482	ည	∢ .	Ct orbit/ear/tossa w/o&w/dye	00.0	4.0	e s	0.00	X X X	70546	بر بر	۲ -	Mt anglograph usau w/ox/w/cyc	0.00	0.55	550		XXX
70482	56	∢ •	Ct orbit/ear/tossa w/o&w/dye	£	0.40	C+:0	0.10	VVV	70547	07	< ⊲	Mr angiograph nead w/occw/dyc	1 20	67.8	NA.	0.09	XXX
70480	Ç	۲.	Ct maxillotaciai w/o dye	+ 000	70.4	(<u> </u>	000	***	70547	JL	. ∢	Mr angiography neck w/o dve	000	8.42	Z	0.00	XXX
70486	<u>)</u> ;	∢ •	CI maxillotacial w/o dye	0.00	3.00	27.0	0.00	XXX	70547	2 %	(∢	Mr angiography neek w/o dve	1.20	0.37	0.37	80.0	XX
70407	07	< <	Ct maximulacian w/o uye	1 30	4 88	S A	0.00	XXX	70548	2	: ≺	Mr angiography neck w/dve	1.20	9.41	NA	0.08	XXX
70487	Ţ	< ∢	C maxillofacial w/dve	000	4.49	×	000	XXX	70548	TC	₹	Mr angiography neck w/dye	0.00	9.04	NA	0.00	XXX
70487	2,0	: ∢	Ct maxillofacial w/dve	1.30	0.40	0,40	0.09	XXX	70548	56	<	Mr angiography neck w/dye	1.20	0.37	0.37	80:0	XXX
70488	3	: <	Ct maxillofacial w/o & w/dve	1.42	86.5	NA	0.10	XXX	70549		¥	Mr angiograph neck w/o&w/dye	1.80	13.31	NA	0.13	XXX
70488	77	٧	Ct maxillofacial w/o & w/dye	0.00	5.55	NA	0.00	XXX	70549	IC	٧	Mr angiograph neck w/o&w/dye	0.00	12.76	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.44	0.44	60'0	XXX	70549	56	¥	Mr angiograph neck w/o&w/dye	1.80	0.55	0.55	0.12	XX
70490		٧	Ct soft tissue neck w/o dye	1.28	3.79	NA	0.09	XXX	70551		K	Mri brain w/o dye	1.48	7.99	Y.	0.11	XXX
70490	C	٧	Ct soft tissue neck w/o dye	0.00	3.40	NA	0.00	XXX	70551	CC	¥	Mri brain w/o dye	0.00	7.53	Y.	0.00	XXX
70490	56	٧	Ct soft tissue neck w/o dye	1.28	0.39	0.39	0.09	XXX	70551	56	∢ .	Mri brain w/o dye	2.48	0.46	0.46	0.10	XXX
70491		< -	Ct soft tissue neck w/dye	1.38	4.69	Š.	60.0	XXX	70552	Ę	₹ <	Mr. brain w/dye	0.00	0.00	K Z	0.00	X X X
70491	2 3	∢ .	Ct soft tissue neck w/dye	0.00	07.4	K 2	0.00	X XX	70552	ع د	τ <	Mri brain w/dye	0.00	0.55	550	1300	XXX
70491	56	۷ ۰	Ct soft tissue neck w/dye	85.1	6.43	0.4% V 4%	80.0	XXX YYY	70553	7	< ∢	Mri brain w/o & w/dve	2.36	10.19	S Z	0.17	X
70407	Ţ	< ∢	Ct oft tour nek w/o & w/dve	000	5.33	S N	000	XXX	70553	TC	۷.	Mri brain w/o & w/dye	0.00	9.47	ΑN	0.01	XXX
70492	26	: ∢	Ct sft tsue nck w/o & w/dve	1.45	0.45	0.45	0.10	XXX	70553	56	¥	Mri brain w/o & w/dye	2.36	0.73	0.73	91.0	XX
70496		Ε «	Ct angiography, head	1.75	9.83	NA	0.13	XXX	70554		Ą	Furri brain by tech	2.11	9.41	NA	0.15	XXX
70496	JC	Α	Ct angiography, head	00.0	9.30	NA	000	XXX	70554	JC	∢	Fmri brain by tech	0.00	8.74	NA.	0.01	XXX
70496	56	٧	Ct angiography, head	1.75	0.53	0.53	0.12	XXX	70554	56	4	Fmri brain by tech	2.11	99.0	99.0	0.15	XXX
70498		٧	Ct angiography, neck	1.75	6.77	NA	0.12	XXX	70555	ě	ပ	Fmri brain by phys/psych	0.00	Y Y	ď ;	0.00	X
70498	7C	4	Ct angiography, neck	0.00	9.23	K.	0.00	XXX	2022	⊇ ;	. د	ring orain by phys/psych	9.6	X .	77.	0.00	ξ λ
70498	56	4	Ct angiography, neck	1.75	0.54	0.54	0.12	XXX	55507	97	∢ (rmri oram by phys/psych	5.24	7.7		9.0	× × ×
70540	(∢ .	Mri orbit/face/neck w/o dye	1.35	7.65	K Z	0.10	X X X	70557	Ţ	ی ر	Mri brain w/o dye	000	ξ 4	Z Z	900	XXX
70540	2 :	∢ .	MIN OFDIVIACE/BECK W/O dye	00.0	* 5	Ç Ç	8.0	222	15501	2 %	> <	Mri brain m/o dva	2 00	92.1	3,4	0.70	XXX
70540	56	K	Mri orbit/tace/neck w/o dye	55.1	0.47	0.42	ΑΩ.	YYY	10001	0.7	<	Mill mans w/o uye	2.30	OC.1	ord II bio) · ·	į
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	Keserved. ² If values	d. es are rei	Reserved. 2 If values are reflected for codes not payable by Medicare, please note that	re, please not		these values have been	peen			2 If valu	s are refl	If values are reflected for codes not payable by Medicare, please note that these values have been	rre, please not	e that these v	alues bave b	cen	
	establish	ned as a	established as a courtesy to the general public and are not used for Medicare payment	t used for Me	edicare pay	nent.	711 - Can Only			establish	ed as a co	established as a courtesy to the general public and are not used for Medicare payment. The budgest managing countries from the Adioparactic demonstration is not reflected in the DVII to for CPT.	ot used for Mo	edicare paym	ent. ed in the 9 \	Tis for CPT	
	The bu	idget ner	The budget neutrality reduction from the chiropractic demonstration is not make 09040, 08041, and 08042. The required reduction will only be reflect.	emonstration	i is not refle reflected in	reflected in the KVUs ed in the files used for	reflected in the KVUs for CPT ed in the files used for			codes 98	aget neut 1940, 989	The budget neutrality reduction from the corropractic demonstration is not relieved in the K YOS codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	remonstration will only be	reflected in the	be files used	for sol	
	Medican	Medicare payment	ant.	in the second						Medicar	Medicare payment.		. ;				
	Global	totals fc	dobal totals for malpractice RVUs may not sum due to rounding	o rounding.						Cioba	totals tor	Global totals for maigractice RVUs may not sum due to rounding.	o rounding.				

CPT'-7				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice		CPT'3	:		:	Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	į
SOUTH PARTY	NO.	Status	s Mari bensin sa/dana	900	9 Z	e v	804	XXX	71100	DOM	SURIUS A	V my ocom of ribs	200	200	5 V	500	XXX
70660	Ç	ي ز	And bearing without	00.0	4 N	Q V	00.0	XXX	71100	J.	ξ ∢	Visit exam of the	77.0	050	Y AN	000	XXX
70550	ې ز	ا	Mri brain wide	3.20	0.07	0.07	0.00	XXX	21100	, y	< ∢	X-ray exam of ribe	0.00	200	0.07	0.00	XXX
70550	24	t C	Mr. hrain w/o & w/dve	000	Y.	Z	000	XXX	10117	ì	: ∢	X-rav exam of ribs/chest	0.27	0.70	Ž	0.02	XX
70559	TC	o Q	Mri brain w/o & w/dye	0.00	Z Y	Ϋ́	0.00	xxx	10117	ıc	: ∢	X-ray exam of ribs/chest	00.0	0.61	NA A	000	XXX
70559	56	٧	Mri brain w/o & w/dye	3.20	1.07	1.07	0.23	XXX	71101	56	¥	X-ray exam of ribs/chest	0.27	90.0	80.0	0.02	XXX
71010		Ą	Chest x-ray	0.18	0.38	Ϋ́	0.01	XXX	71110		¥	X-ray exam of ribs	0.27	0.71	NA	0.02	XXX
71010	IC	4	Chest x-ray	0.00	0.33	Y V	00:0	XXX	71110	TC	٧	X-ray exam of ribs	0.00	0.63	Ϋ́	00.0	XXX
71010	56	٧	Chest x-ray	0.18	0.05	0.05	0.01	XXX	71110	56	Ą	X-ray exam of ribs	0.27	80.0	0.08	0.02	XXX
71015		4	Chest x-ray	0.21	0.55	N A	0.01	XXX	711111		4	X-ray exam of ribs/chest	0.32	96'0	Ϋ́	0.02	XXX
71015	7	∢	Chest x-ray	000	0.48	Ν	0.00	XXX	111117	TC	٧	X-ray exam of ribs/chest	0.00	0.87	Ϋ́	00:0	XXX
71015	70	₹	Chest x-ray	0.21	0.07	0.07	0.01	XXX	71111	56	¥	X-ray exam of ribs/chest	0.32	60:0	60.0	0.02	XXX
71020		٧	Chest x-ray	0.22	0.52	Ϋ́	10'0	XXX	71120		Ą	X-ray exam of breastbone	0.20	0.57	ΝA	0.01	XXX
71020	70	٧	Chest x-ray	0.00	0.46	NA	0.00	XXX	71120	10	¥	X-ray exam of breastbone	0.00	0.51	NA	0.00	XXX
71020	56	ď	Chest x-ray	0.22	0.07	0.02	0.01	XXX	71120	56	A	X-ray exam of breastbone	0.20	90:0	90.0	0.01	XX
71021		Ą	Chest x-ray	0.27	0.65	NA	0.02	XXX	71130		ď	X-ray exam of breastbone	0.22	0.70	NA V	0.02	XXX
71021	J.C	K	Chest x-ray	0.00	0.57	NA	0.00	XXX	71130	IC	¥	X-ray exam of breastbone	0.00	0.63	NA	0.00	XXX
71021	26	٧	Chest x-ray	0.27	80.0	0.08	0.01	XXX	71130	56	٧	X-ray exam of breastbone	0.22	0.07	0.07	0.02	XXX
71022		∢	Chest x-ray	0.31	0.85	Ν	0.02	XXX	71250		٧	Ct thorax w/o dye	1.16	3.76	ΥN	80.0	XXX
71022	Σ	¥	Chest x-ray	0.00	0.75	NA	0.00	XXX	71250	C	٧	Ct thorax w/o dye	0.00	3.40	NA	0.00	XXX
71022	36	¥	Chest x-ray	0.31	0.10	0.10	0.02	XXX	71250	56	٧	Ct thorax w/o dye	1.16	0.35	0.35	80.0	XXX
71023		٧	Chest x-ray and fluoroscopy	0.38	1.39	Ν	0.02	XXX	71260		٧	Ct thorax w/dye	1.24	4.66	NA A	60.0	XXX
71023	IC	4	Chest x-ray and fluoroscopy	0.00	1.26	NA	0.00	XXX	71260	TC	∢	Ct thorax w/dye	0.00	4.28	ΝA	0.00	XXX
71023	56	٧	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0,02	XXX	71260	56	٧	Ct thorax w/dye	1.24	0.38	0.38	80:0	XXX
71030		∢	Chest x-ray	0.31	0.82	NA NA	0.02	XXX	71270		∢	Ct thorax w/o & w/dye	1.38	5.80	NA	0.10	XXX
71030	C	٧	Chest x-ray	0.00	0.73	Ν	0.00	XXX	71270	70	٧	Ct thorax w/o & w/dye	0.00	5.37	Υ	0.00	XXX
71030	70	¥	Chest x-ray	0.31	0.10	0.10	0.02	XXX	71270	56	¥	Ct thorax w/o & w/dye	1.38	0.42	0.42	60.0	XXX
71034	í	∢ .	Chest x-ray and fluoroscopy	0.46	99:	Y ;	0.03	XXX	71275	i	۷.	Ct angiography, chest	1.92	7.19	Ž;	0.13	XX
71034	ည	∢ .	Chest x-ray and fluoroscopy	0.00	5.5	A .	000	XXX	71275	ည	۷.	Ct angiography, chest	0.00	1979	A S	10:0	XXX
71034	36	∢ •	Chest x-ray and fluoroscopy	0.46	0.15	0.15	0.02	XXX	71275	26	< ∙	Ct angiography, chest	1.92	0.58	0.58	0.13	XXX
71035	Ç	∢ •	Chest x-ray	0.18	60.0	€ <u>*</u>	000	XXX	71550	7.	< •	Mr chest w/o dye	04.1	8.80	K 2	1.0	χχ. Χ.
71035	ې د	< 4	Chest x-ray	0.00	0.04	0.05	000	XXX	71550	2 %	< <	Mri chest w/o dye	1.46	0.45	0.45	0.00	XXX
71040	ì	: ∢	Contrast x-ray of bronchi	0.58	1.85	NA V	0.02	XXX	71551		₹	Mri chest w/dve	1.73	6.67	N.	0.12	XXX
71040	JC	⋖	Contrast x-ray of bronchi	00:0	1.67	NA	0.00	XXX	71551	TC	4	Mri chest w/dye	0.00	9.43	ΝA	000	XXX
71040	56	<	Contrast x-ray of brouchi	0.58	0.18	81.0	0.05	XXX	71551	56	*	Mri chest w/dye	1.73	0.54	0.54	0.12	XXX
71060		٧	Contrast x-ray of bronchi	0.74	2.87	ΝA	0.05	XXX	71552		٧	Mri chest w/o & w/dye	2.26	12,31	N.A	0.16	XXX
71060	TC	∢	Contrast x-ray of bronchi	0.00	2.63	NA	0.00	XXX	71552	C	4	Mri chest w/o & w/dye	0.00	11.62	ΝΑ	10.0	XXX
71060	56	4	Contrast x-ray of bronchi	0.74	0.24	0.24	0.05	XXX	71552	56	٧	Mri chest w/o & w/dye	2.26	69.0	69.0	0.15	XXX
71090		ပ	X-ray & pacemaker insertion	0.00	NA	N.	0.00	XXX	71555		œ	Mri angio chest w or w/o dye	1.8.1	8.69	NA	0.12	XXX
71090	C	ပ	X-ray & pacemaker insertion	0.00	NA	NA	0.00	XXX	71555	TC	ď	Mri angio chest w or w/o dye	0.00	8.13	NA	0.01	XXX
71090	76	٧	X-ray & pacemaker insertion	0.54	0.18	0.18	0.03	XXX	71555	56	æ	Mri angio chest w or w/o dye	1.81	0.56	0.56	0.12	XXX
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	Reserved	ved.	Should be a second of the seco	1000	de de la change	died action				Reserved.	j.	(eserved) If any one medicated for another and manufacture Madisane advantages that there exhans have been	of the charge of the charge	that those	de constant		
	establis	shed as a	it values are reflected for codes not payable by includare, please note that messe values have occur- established as a courtesy to the general public and are not used for Medicare payment.	are, prease nore	dicare payment.	vanics nave nent.	Deci			establish	ed as a co	is values are removed not course not payable by predicare, picase note had mese values stablished as a courtesy to the general public and are not used for Medicare payment.	are, prease nore tot used for Mea	dicare payme	AILLES MAYE D III.	Ē	
	The t	budget ne	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflec	ted in the R	VUs for CPT			The bu	dget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflect	ed in the RV	Us for CPT	
	codes	98940, 9	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	on will only be r	eflected in	the files use	l for			codes 98	odes 98940, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be r	reflected in th	e files used	for	
	*Clobs	Meuicare payment. Global totals for r	menicare payment. Clobal totals for materiace RVI is may not sum due to rounding	to rounding						Global	totals for	oremeate payment. Global totals for maloractice RVI/s may not sum due to rounding.	to roundine.				
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CPT ¹²				Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice		CPT'31				Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice	-
HCPCS	Mod	Status		RVUs ^{2,3}	RVUs	RVU8	RVUs***	Global	HCPCS	Mod	Status	Description	RVUs.	RVUs**	RVUs	RVUs	Global
72010		¥	X-ray exam of spine	0.45	1.50	NA :	0.03	XXX	72120	į	∢ .	X-ray exam of lower spine	0.22	01.1	ď.	0.03	X X X
72010	TC	∢	X-ray exam of spine	0.00	1.33	Y Z	0.00	XXX	72120	10	∢	X-ray exam of lower spine	00.0	1.01	ď.	0.00	3
72010	56	٧	X-ray exam of spine	0.45	0.17	0.17	0.03	XXX	72120	56	Ą	X-ray exam of lower spine	0.22	0.09	60.0	0.03	XXX
72020		¥	X-ray exam of spine	0.15	0.43	Ϋ́ V	0.02	XXX	72125		٧	Ct neck spine w/o dye	1.16	3.79	Υ Z	0.09	XXX
72020	TC	٧	X-ray exam of spine	0.00	0.38	NA	0.00	XXX	72125	2	¥	Ct neck spine w/o dye	0.00	3.4	Z Z	0.00	XXX
72020	56	4	X-ray exam of spine	0.15	0.05	0.05	0.01	XXX	72125	56	V	Ct neck spine w/o dye	1.16	0.35	0.35	80.0	X
72040		∢	X-ray exam of neck spine	0.22	0.75	ΝΆ	0.02	XXX	72126		Ą	Ct neck spine w/dye	1.22	4.68	NA	60.0	XXX
72040	IC	<	X-ray exam of neck spine	00'0	19.0	NA	0.00	XXX	72126	IC	∢	Ct neck spine w/dye	0.00	4.31	N	0.00	XXX
72040	56	¥	X-ray exam of neck spine	0.22	0.08	0.08	0.02	XXX	72126	76	Ą	Ct neck spine w/dye	1.22	0.37	0.37	60.0	XXX
72050		<	X-ray exam of neck spine	0.31	0.99	ΝA	0.03	XXX	72127		4	Ct neck spine w/o & w/dye	1.27	5.78	NA	60'0	XXX
72050	C	Υ	X-ray exam of neck spine	00'0	0.89	NA	0.00	XXX	72127	TC	٧	Ct neck spine w/o & w/dye	0.00	5.39	NA	0.00	XXX
72050	26	٧	X-ray exam of neck spine	0.31	0.10	0.10	0.03	XXX	72127	26	Ą	Ct neck spine w/o & w/dye	1.27	0.39	0.39	60.0	XXX
72052		¥	X-ray exam of neck spine	0.36	1.32	NA	0.03	XXX	72128		¥	Ct chest spine w/o dye	1.16	3.78	NA	80.0	XXX
72052	TC	¥	X-ray exam of neck spine	0.00	1.20	N A	0.00	XXX	72128	C	Ą	Ct chest spine w/o dye	0.00	3.42	NA	0.00	XXX
72052	56	٧	X-ray exam of neck spine	0.36	0.12	0.12	0.03	XXX	72128	56	¥	Ct chest spine w/o dye	1,16	0.35	0.35	80.0	XXX
72069		<	X-ray exam of trunk spine	0.22	0.72	NA	0.03	XXX	72129		٧	Ct chest spine w/dyc	1.22	4.69	X	0.09	XXX
72069	C	<	X-ray exam of trunk spine	0.00	0.64	NA	0.00	XXX	72129	TC	€	Ct chest spine w/dye	0.00	4.32	NA	0.00	XXX
72069	36	. ⋖	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX	72129	56	¥	Ct chest spine w/dye	1.22	0.37	0.37	60'0	XXX
72070	i	<	X-ray exam of thoracic spine	0.22	0.60	N.	0.02	XXX	72130		A	Ct chest spine w/o & w/dye	1.27	5.83	NA	60'0	XXX
72070	T.	<	X-ray exam of theracic spine	0.00	0.53	NA	0.00	XXX	72130	C	٧	Ct chest spine w/o & w/dye	0.00	5.44	NA	00'0	XXX
72070	56	: <	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX	72130	56	₹	Ct chest spine w/o & w/dye	1.27	0.39	0.39	80.0	XXX
72072		<	X-ray exam of thoracic spine	0.22	69.0	ΑN	0.02	XXX	72131		∢	Ct lumbar spine w/o dye	1.16	3.77	NA	80.0	XXX
72072	IC	<	X-ray exam of thoracic spine	0.00	0.63	NA	0.00	XXX	72131	JC	¥	Ct lumbar spine w/o dye	0.00	3.42	NA	000	XXX
72072	56	٧	X-ray exam of thoracic spine	0.22	0.07	0.07	10.0	XXX	72131	56	∢	Ct lumbar spine w/o dye	1.16	0.36	0.36	80.0	XXX
72074		٧	X-ray exam of thoracic spine	0.22	0.87	NA	0.02	XXX	72132		Ą	Ct lumbar spine w/dye	1.22	4.67	A.	60.0	XXX
72074	CC	∢	X-ray exam of thoracic spine	00.0	0.80	NA	00.0	XXX	72132	TC	¥	Ct lumbar spine w/dye	0.00	4.30	N A	0.00	XXX
72074	56	٧	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX	72132	56	∢	Ct lumbar spine w/dye	1.22	0.37	0.37	0.09	XXX
72080		4	X-ray exam of trunk spine	0.22	69.0	NA	0.03	XXX	72133		K	Ct lumbar spine w/o & w/dye	1.27	5.78	N.	60.0	XXX
72080	C	٧	X-ray exam of trunk spine	00.0	0.61	NA	0.00	XXX	72133	TC	¥	Ct lumbar spine w/o & w/dye	0.00	5.39	N.	0.00	XXX
72080	97	٧	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX	72133	56	٧	Ct lumbar spine w/o & w/dye	1.27	0.39	0.39	60:0	XXX
72090		<	X-ray exam of trunk spine	0.28	0.98	NA	40.0	XXX	72141		∢	Mri neck spine w/o dye	1.60	6.92	NA	0.12	XXX
72090	TC	4	X-ray exam of trunk spine	0.00	0.88	ΝA	0.00	XXX	72141	JC	٧	Mri neck spine w/o dye	0.00	6.42	Y.	0.00	X
72090	56	¥	X-ray exam of trunk spine	0.28	0.10	0.10	0.03	XXX	72141	56	۷.	Mri neck spine w/o dye	1.60	0.50	0.50	0.12	XX
72100		٧	X-ray exam of lower spine	0.22	0.79	NA	0.03	XXX	72142		٧	Mri neck spine w/dye	1.92	96.8	Y.	0.14	XX
72100	10	4	X-ray exam of lower spine	0.00	0.72	¥.	0.00	XXX	72142	<u>ا</u>	∢ .	Mri neck spine w/dye	0.00	8.36	Y ;	0:01	XXX
72100	76	₹	X-ray exam of lower spine	0.22	0.08	0.08	0.02	XXX	72142	56	∢	Mri neck spine w/dye	1.92	0.00	0.60	0.14	XXX
72110		Ą	X-ray exam of lower spine	0.31	1.07	Y.	0.03	XXX	72146		٧	Mri chest spine w/o dye	1.60	6.94	Z :	0.12	XXX
72110	CC	∢	X-ray exam of lower spine	0.00	96.0	ΥZ	0.00	XXX	72146	7C	٧	Mri chest spine w/o dye	0.00	4,0	Ϋ́	0.00	XX
72110	56	٧	X-ray exam of lower spine	0.31	0.10	0.10	0.03	XXX	72146	56	∢	Mri chest spine w/o dye	1.60	0.50	0.50	0.12	XX
72114		Y	X-ray exam of lower spine	0.36	1.54	Y Y	0.04	XXX	72147		٧	Mri chest spine w/dye	1.92	7.78	Z Z	0.14	XXX
72114	TC	∢	X-ray exam of lower spine	0.00	1.40	Z	0.00	XXX	72147	70	٧	Mri chest spine w/dye	0.00	7.19	Y.	0.01	X
72114	56	¥	X-ray exam of lower spine	0.36	0.13	0.13	0.04	XXX	72147	92	¥	Mri chest spine w/dye	1.92	0.60	0.60	0.13	XX
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	order 6	onaget ne	The budget neutrality reduction from the contribution will only be reflected in the files used for	nemonstration	is not retic reflected in	the files use	d for			codes 9	10get Jieur 8940, 989	the budget mediality reduction from the components Gemonstration is not reflected in the files used for	emonstration will only be	reflected in th	ed in me ny ie files used	or so	
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73000		A	X-rav exam	0.16	0.55	Z Z	0.02	XXX	73115	S	A	Contrast x-ray of wrist	0.54	2.26	AN AN	0.04	xx
73000	70	<	X-ray exam of collar bone	000	0.50	AN	00'0	XXX	73115	C	V	Contrast x-ray of wrist	0.00	2,06	Y.	000	XXX
73000	26	¥	X-ray exam of collar bone	0.16	90.0	90.0	0.02	XXX	73115	56	٧	Contrast x-ray of wrist	0.54	0.20	0.20	0.04	xxx
73010		∢	X-ray exam of shoulder blade	0.17	09.0	NA	0.02	XXX	73120		¥	X-ray exam of hand	0.16	0.52	Ϋ́	0.01	xxx
73010	IC	A	X-ray exam of shoulder blade	0.00	0.53	ΝA	0.00	XXX	73120	10	٧	X-ray exam of hand	0.00	0.46	Ν	0.00	XXX
73010	56	Y	X-ray exam of shoulder blade	0.17	0.02	0.07	0.02	XXX	73120	56	V	X-ray exam of band	0.16	90:0	90.0	0.01	XXX
73020		¥	X-ray exam of shoulder	0.15	4:	Z Z	0.02	XXX	73130	į	₹ .	X-ray exam of hand	0.17	0.62	V.	0.02	X
73020	٦٠ -	Κ	X-ray exam of shoulder	0.00	0.38	Y.	0.00	XXX	73130	1C	≺	X-ray exam of hand	0.00	0.57	Y.	0.00	XX
73020	56	٧	X-ray exam of shoulder	0.15	0.05	0.05	0.02	XXX	73130	56	٧	X-ray exam of hand	0.17	0.06	90:0	0.05	X
73030		∢:	X-ray exam of shoulder	0.18	0.57	X Y	0.02	XXX	73140		*	X-ray exam of finger(s)	0.13	0.70	Y Z	0.02	X
73030	ပ္	K	X-ray exam of shoulder	000	0.50	Ν	0.00	XXX	73140	TC	٧	X-ray exam of finger(s)	0.00	0.65	YY.	0.00	XX
73030	70	۷.	X-ray exam of shoulder	0.18	0.07	0.07	0.02	XXX	73140	56	∢ .	X-ray exam of finger(s)	0.13	0.05	0.05	0.02	XX
73040	ę.	∢ .	Contrast x-ray of shoulder	0.54	2.13	¥;	0.05	XXX	73200	Š	۷ ۰	Ct upper extremity w/o dye	60.1	3.73	Y.	80.0	XX
73040	2	K	Contrast x-ray of shoulder	0.00	5.	¥ ;	0.00	XXX	73200	ည (∢ .	Ct upper extremity w/o dye	0.00	3.40	Y.	000	XXX
73040	56	Y	Contrast x-ray of shoulder	0.54	0.18	0.18	0.05	XXX	73200	56	٧.	Ct upper extremity w/o dye	60'1	0.34	0.34	80:0	XX
73050		∢	X-ray exam of shoulders	0.20	0.78	K K	0.03	XXX	73201		¥	Ct upper extremity w/dye	1.16	4.61	Y.	80.0	XX
73050	ıc	A	X-ray exam of shoulders	000	0.70	Ϋ́	0.00	XXX	73201	C	Ą	Ct upper extremity w/dye	0.00	4.26	ΥZ	0.00	XXX
73050	56	4	X-ray exam of shoulders	0.20	0.08	80.0	0.03	XXX	73201	56	∢	Ct upper extremity w/dye	1.16	0.35	0.35	80.0	XX
73060		V	X-ray exam of humerus	0.17	0.54	Z Y	0.02	XXX	73202		Ą	Ct uppr extremity w/o&w/dye	1.22	6.10	Y Z	60.0	XX
73060	77	∢	X-ray exam of humerus	0.00	0.48	Ϋ́	0.00	XXX	73202	10	¥	Ct uppr extremity w/o&w/dye	0.00	5.72	ΝĄ	0.00	XXX
73060	79	V	X-ray exam of humerus	0.17	0.05	0.05	0.02	XXX	73202	56	٧	Ct uppr extremity w/o&w/dye	1.22	0.37	0.37	80.0	XXX
73070		¥	X-ray exam of elbow	0.15	0.55	Y.	0.02	XXX	73206		∢	Ct angio upr extrm w/o&w/dye	1.81	6.47	۷ Z	0.12	XXX
73070	Ω	¥	X-ray exam of elbow	0.00	0.50	NA.	0.00	XXX	73206	10	¥	Ct angio upr extrm w/o&w/dye	0.00	5.91	N.	10.0	X
73070	56	¥	X-ray exam of elbow	0.15	0.05	0.05	0.02	XXX	73206	56	٧	Ct angio upr extrm w/o&w/dye	1.81	0.55	0.55	0.1	X
73080		¥	X-ray exam of elbow	0.17	0.72	Y.	0.02	XXX	73218		٧	Mri upper extremity w/o dye	1.35	7.92	Y N	60.0	XX
73080	J.	4	X-ray exam of elbow	0.00	99.0	Y Z	0.00	XXX	73218	J.	¥	Mri upper extremity w/o dye	0.00	7.49	Ϋ́	0.00	XX
73080	56	∢ .	X-ray exam of elbow	0.17	0.00	0.06	0.02	XXX	73218	56	< ⋅	Mri upper extremity w/o dye	1.35	0.43	0.43	0.00	XX
73085	6	∢ .	Contrast x-ray of elbow	0.54	/s: ,	Y S	0.04	XXX	61257	í	∢ .	Mri upper extremity w/dye	79.1	2/.8	¥;	21.0	ž
73085) (1)	∢ -	Contrast x-ray of elbow	0.00	89.	A S	0.00	XXX	73219	2 8	۷.	Mri upper extremity w/dye	0.00	8.21	ν.	0.00	XX
73085	70	∢ •	Contrast x-ray of elbow	0.54	070	0.20	9.0	XXX	9175/	97	∢ <	Mr. upper extremity w/dye	1.62	15.0	(C)	0.12	XXX
73000	Į.	< <	X-ray exam of forearm	0.00	0.04	Z Z	70.0	XXX	73720	J.L.	< ⊲	Min uppi extremity w/ox/w/uye	0.00	10.01	C V	0.10	× × ×
73090	26	< ∢	X-ray exam of forearm	0.00	0.05	0.05	0.02	XXX	73220	26	< <	Mri appreximenty w/o&w/dve	2.15	19.0	29.0	0.15	X
73092		₹	X-ray exam of arm, infant	0.16	0.59	Ϋ́	0.01	XXX	73221		₹.	Mri joint upr extrem w/o dye	1.35	7.51	NA	0.11	XXX
73092	JC	4	X-ray exam of arm, infant	0.00	0.54	NA	0.00	XXX	73221	C	¥	Mri joint upr extrem w/o dye	0.00	7.06	NA A	0.00	XXX
73092	56	¥	X-ray exam of arm, infant	0.16	0.05	0.05	10.0	XXX	73221	56	٧	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.11	XXX
73100		4	X-ray exam of wrist	0.16	0.63	N.	0.02	XXX	73222		¥	Mri joint upr extrem w/dye	1.62	8.06	NA	0.12	XXX
73100	IC	A	X-ray exam of wrist	0.00	0.56	NA	0.00	XXX	73222	TC	∢	Mri joint upr extrem w/dye	0.00	7.55	NA	0.00	XXX
73100	76	Ą	X-ray exam of wrist	0.16	0.07	0.07	0.02	XXX	73222	56	4	Mri joint upr extrem w/dye	1.62	0.51	0.51	0.12	XXX
73110		¥	X-ray exam of wrist	0.17	0.76	Ϋ́	0.02	XXX	73223		٧	Mri joint upr extr w/o&w/dye	2.15	9.90	NA	0.16	XXX
73110	2	¥	X-ray exam of wrist	0.00	0.70	NA A	0.00	XXX	73223	C	¥	Mri joint upr extr w/o&w/dye	0.00	9.23	NA	0.01	XX
73110	26	¥	X-ray exam of wrist	0.17	90:0	90.0	0.02	XXX	73223	56	A	Mri joint upr extr w/o&w/dye	2.15	0.67	29.0	91.0	XX
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	establish	bed as a	as values are reducted for cours, not payable by incurred by prease, not used for Medicare payment.	used for Me	dicare payn	tent.	3			establish	ed as a co	isstablished as a courtesy to the general public and are not used for Medicare payment.	ot used for Mea	dicare payme	eft.	3	
	The bu	udget ner	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs	monstration	is not reflec	reflected in the RVUs for CPT and in the files used for	VUs for CPT I for			The bu	dget neutr	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 88040 98041 and 88042. The required reduction will only be reflected in the files used for	lemonstration	is not reflecte	d in the RVI	Js for CPT	
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	Globa	l totals fi	Global totals for malpractice RVUs may not sum due to rounding	rounding.						Global	totals for	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				

CPT ^{C3} /				Physi- cian Work	Non- Facility PE	Facility	Mal- Practice		CPT'3				Physi- cian Work	Non- Facility PE	Facility PE	Mail- Practice	
'n	Mod	Status	Description	RVUs.3	RVUs ^{2,3}	RVU6.	RVUe ^{23,4}	Global	HCPCS	Mod	Status	Description	RVUs.	RVUs.	RVUs-	RVUs***	Global
73225		z	Mr angio upr extr w/o&w/dye	1.73	10.34	ď	0.09	XXX	73590		<	X-ray exam of lower leg	0.17	0.50	¢ :	0.02	X X X
73225	10	z	Mr angio upr extr w/o&w/dye	0.00	9.71	K Z	0.00	xxx	73590	12	Κ	X-ray exam of lower leg	000	0.45	Z Z	0.00	Y YY
73225	56	Z.	Mr angio upr extr w/o&w/dye	1.73	0.63	0.63	0.09	XXX	73590	56	∢	X-ray exam of lower leg	0.17	0.05	0.05	0.02	XXX
73500		Ą	X-ray exam of hip	0.17	0.49	K Z	0.02	XXX	73592		٧	X-ray exam of leg, infant	0.16	0.62	ď.	0.02	XX
73500	7C	¥	X-ray exam of hip	0.00	0.42	ΝĄ	0.00	XXX	73592	JC	<	X-ray exam of leg, infant	0.00	0.57	N.	0.00	XX
73500	56	¥	X-ray exam of hip	0.17	90.0	90.0	0.02	XXX	73592	56	4	X-ray exam of leg, infant	0.16	90.0	90.0	0.02	XX
73510		*	X-ray exam of bip	0.21	0.74	Y.	0.03	XXX	73600		٧	X-ray exam of ankle	0.16	0.56	N A	0.02	××
73510	TC	٧	X-ray exam of hip	00.0	0.67	Ϋ́	00.0	XXX	73600	JC.	٧	X-ray exam of ankle	0.00	0.50	Ϋ́	00:0	XXX
73510	26	¥	X-ray exam of hip	0.21	0.07	0.07	0.03	XXX	73600	56	٧	X-ray exam of ankle	0.16	90'0	90:0	0.02	XXX
73520		¥	X-ray exam of hips	0.26	0.75	Ν	0.03	XXX	73610		¥	X-ray exam of ankle	0.17	0.65	N.	0.02	XXX
73520	TC T	¥	X-ray exam of hips	00.0	99.0	Ϋ́	00.0	XXX	73610	JC	¥	X-ray exam of ankle	0.00	09.0	N.	00:0	XXX
73520	26	Ą	X-ray exam of hips	0.26	60.0	0.09	0.03	XXX	73610	56	∢	X-ray exam of ankle	0.17	90.0	90.0	0.02	XXX
73525		¥	Contrast x-ray of hip	0.54	2.01	NA	0.04	XXX	73615		<	Contrast x-ray of ankle	0.54	2.17	NA	0.05	XXX
73525	JC	Ą	Contrast x-ray of hip	00'0	1.80	NA	00.0	XXX	73615	TC	∢	Contrast x-ray of ankle	0.00	1.95	NA	0.00	XXX
73525	56	×	Contrast x-ray of bip	0.54	0.21	0.21	0.04	XXX	73615	56	4	Contrast x-ray of ankle	0.54	0.22	0.22	50:0	XXX
73530		. O	X-ray exam of hip	0.00	N A	ΑN	0.00	XXX	73620		٧	X-ray exam of foot	91.0	0.53	NA	10.0	XXX
73530	IC	O	X-ray exam of hip	0.00	×	Ν	0.00	XXX	73620	TC	4	X-ray exam of foot	0.00	0,49	NA	0.00	XXX
73530	3,6	×	X-ray exam of hin	0.29	60.0	0.09	0.02	XXX	73620	56	٧	X-ray exam of foot	0.16	0.04	0.04	0.01	XXX
73540	2	; ∢	X-ray exam of nelvis & hins	0.20	06.0	V.	0.03	XXX	73630		V	X-ray exam of foot	0.17	0.64	Ν	0.01	XXX
73540	TC	. ∢	X-ray exam of pelvis & hips	0.00	0.82	Ϋ́	0.00	XXX	73630	21	4	X-ray exam of foot	0.00	0.59	NA	00.0	XXX
73540	2,0	. ∢	X-ray exam of nelvis & hips	0.20	60.0	60.0	0.03	XXX	73630	26	Ą	X-ray exam of foot	0.17	0.05	0.05	0.01	XXX
71547	2	; ∢	X-ray exam sacrollac joint	0.59	097	NA	0.03	XXX	73650	i	۷	X-ray exam of heel	0.16	0.55	NA	0.02	XXX
73547	J	: 4	X-ray exam sacroiliac joint	000	1.35	Y	0.00	XXX	73650	TC	•	X-ray exam of beel	000	0.50	NA	00.00	XXX
73542	26	٠.	X-ray exam, sacrolliac joint	0.59	0.25	0.25	0.03	xxx	73650	56	Ą	X-ray exam of heel	0.16	0.05	0.05	0.02	XXX
73550	3	· «	X-ray exam of thigh	0.17	0.51	NA	0.02	XXX	73660		٧	X-ray exam of toe(s)	0.13	0.62	NA	10.0	XXX
73550	C	. 4	X-ray exam of thigh	0.00	0.45	NA	0.00	XXX	73660	TC	٧	X-ray exam of toe(s)	0.00	0.57	NA	0.00	XXX
73550	26	٧	X-ray exam of thigh	0.17	0.05	0.05	0.02	XXX	73660	56	∢	X-ray exam of toe(s)	0.13	0 .0 4	0.04	0.01	XXX
73560	;	₹ 4	X-ray exam of knee, 1 or 2	0.17	0.59	Z,	0.02	XXX	73700		٧	Ct lower extremity w/o dye	1.09	3.74	NA	80.0	XXX
73560	JC	4	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.00	XXX	73700	JC	Ą	Ct lower extremity w/o dye	00.0	3.41	N A	0.00	XXX
73560	56	٧	X-ray exam of knee, 1 or 2	0.17	90.0	90:0	0.02	XXX	73700	56	∢	Ct lower extremity w/o dye	60:1	0.33	0.33	80.0	XXX
73562		٧	X-ray exam of knee, 3	0.18	0.75	NA	0.02	XXX	73701		٧	Ct lower extremity w/dye	1.16	4.67	NA	80.0	XX
73562	C	¥	X-ray exam of knee, 3	00'0	0.68	NA	0.00	XXX	13701	70	∢	Ct lower extremity w/dye	0.00	4.32	K K	0.00	XXX
73562	56	Ą	X-ray exam of knee, 3	0.18	0.07	0.07	0.02	xxx	73701	56	4	Ct lower extremity w/dye	1.16	0.35	0.35	80.0	XX
73564		¥	X-ray exam, knee, 4 or more	0.22	98'0	K Z	0.03	XXX	73702		٧	Ct Iwr extremity w/o&w/dye	1.22	6.13	Υ X	80.0	X
73564	TC	¥	X-ray exam, knee, 4 or more	0.00	0.78	Ν	00:0	xxx	73702	22	¥	Ct lwr extremity w/o&w/dye	0.00	5.76	Y.	0.00	XX
73564	56	¥	X-ray exam, knee, 4 or more	0.22	0.09	0.00	0.03	XXX	73702	92	¥	Ct lwr extremity w/o&w/dye	1.22	0.37	0.37	80.0	XXX
73565		Ą	X-ray exam of knees	0.17	0.71	Ϋ́	0.02	XXX	73706		∢	Ct angio lwr extr w/o&w/dye	06.1	7.36	NA:	0.13	XX
73565	TC	¥	X-ray exam of knees	0.00	0.64	N A	0.00	XXX	73706	C	Ą	Ct angio lwr extr w/o&w/dye	0.00	6.78	Y Y	0.01	XXX
73565	56	Ą	X-ray exam of knees	0.17	0.08	80.0	0.02	XXX	73706	56	V	Ct angio lwr extr w/o&w/dye	1.90	0.59	0.59	0.13	XX
73580		۷	Contrast x-ray of knee joint	0.54	2.93	Ϋ́	90.0	XXX	73718		¥	Mri lower extremity w/o dye	1.35	7.81	Y.	0.10	XXX
73580	TC	Ą	Contrast x-ray of knee joint	00'0	2.68	Ϋ́	0.00	XXX	73718	22	٧	Mri lower extremity w/o dye	0.00	7.38	Z.	0.00	X
73580	26	٨	Contrast x-ray of knee joint	0.54	0.25	0.25	90:0	XXX	73718	56	∢	Mri lower extremity w/o dye	1.35	0.42	0.42	0.10	XXX
-	CPT coc	des and	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medi	cal Associa	tion. All Ri	hts			CPT co	des and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associati	on. All Rigl	ıts	
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0 r.	stabüshe The hud	ned as a c	established as a courtesy to the general public and are not used for interactions. The hidden neutrality reduction from the chicographic demonstration is not in	t used for ivic	is not reflected	rent. red in the R	reflected in the RVI)s for CPT			The but	foet neut	stabusticu as a courtesy to the general public and are not used for interneate payment. The budgest neutrality reduction from the chicopractic demonstration is not reflected in the RVUs for CPT.	t used for lyter lemonstration	is not reflect	nt. ed in the RV	Us for CPT	
ō	odes 986	1940, 989	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	the files used	for			86 sapos	940,989	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be r	reflected in th	e files used	for	
~	dedicare	Medicare payment	at.							Medicare	Medicare payment.						
**	Globalt	totals for	Global totals for materactice RVUs may not sum due to rounding	rounding.						Global	totals for	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				

	Global	XXX	X X	X X	XXX	XXX	XX	XXX	X X	XXX X	XX	XXX	XXX	XXX	XXX	X X X	XX	XXX	XX	XX	XXX	XXX	XXX	XXX	XXX	žž	XXX	XX	XXX	XXX	XXX	XX	XXX	XXX	ς χ.χ.χ. Χ.Χ.Χ.	Š.		←
Mal- Practice	RVUe.	0.10	0.00	0.10	0.00	0.12	91.0	0.01	0.10	0.13	0.12	0.00	0.00	0.04	0.03	0.00	0.03	0.00	0.03	000 000	0.04	0.00	0.00	0.05	0.00	0.05	0.00	0.0 40.0	90.0	0.06	0.05	0.00	0.05	0.05	900	oo.	peen	tVUs for CP ed for
Facility	RVUs ² .	¥ :	¥ 3	¥ V	Ν	0.52	¥Z:	AN C	0.69 NA	C Z	0.55	N	Ϋ́	0.15	¥.	4 E	Y V	NA	0.14	¢ ¢ Z Z	0.16	Ϋ́N	NA V	S V	Y.	0.21 NA	NA	0.21	e s	0.28	Ϋ́	Y.	0.21	K Z	7 L	U.Z.I ation. All R	values have nent.	cted in the R the files use
Non- Facility PF	RVUs ^{2,3}	6.88	24.0	9.72	61.6	0.52	10.56	78.6	690	8 10	0.55	NA	NA	0.15	. 58	/4/	1.82	1.68	0.14	5.7	0.16	NA	NA S	2.08	1.87	0.21	2.10	0.21	3.5.5	0.28	2.49	2.28	0.21	2.87	00.7	0.21 dical Associ	ite that these	n is not refle reflected in
Physi- cian Work	RVUs ^{2,3}	1.46	00.0	6 7	00.0	1.73	2.26	0.00	2.26	08.1	282	0.00	0.00	0.48	0.36	0.00	0.46	0.00	0.46	0.53	0.53	00'0	0.00	69.0	0.00	0.69	0.00	69.0	16:0	0.91	69:0	0.00	69.0	69.0	00.0	o.oy American Me	are, please no ot used for N	demonstratio a will only be
	Description	Mri abdomen w/o dye	Mri abdomen w/o dye	Mri abdomen w/o dye	Mri abdomen w/dye	Mri abdomen w/dye	Mri abdomen w/o & w/dye	Mri abdomen w/o & w/dye	Mri abdomen w/o & w/dye	Mri angio, abdom w orw/o dye	Mri angio, abdom w orw/o dye Mri angio, abdom w orw/o dye	X-ray exam of peritoneum	X-ray exam of peritoneum	X-ray exam of peritoneum	Contrst x-ray exam of throat	Control x-ray exam of throat	Contrast x-ray, esophagus	Contrast x-ray, esophagus	Contrast x-ray, esophagus	Cine/vid x-ray, throat/esoph	Cine/vid x-ray, throat/esoph	Remove esophagus obstruction	Remove esophagus obstruction	X-ray exam, upper gi tract	X-ray exam, upper gi tract	X-ray exam, upper gi tract X-ray exam, upper gi tract	X-ray exam, upper gi tract	X-ray exam, upper gi tract	X-ray exam, upper gi tract	X-ray exam, upper gi uaci X-ray exam, upper gi tract	Contrat x-ray uppr gi tract	Contrst x-ray uppr gi tract	Contrat x-ray uppr gi tract	Control x-ray uppr gi tract	Counst x-ray uppr gi tract	26 A Contrat x-ray uppr gi tract 0.09 American Medical Association. All Rights CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been stablished as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 88940, 88941, and 98942. The required reduction will only be reflected in the files used for Medicar payment of the files used for the files of the files
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	Mod	1	2 2	97	TC	26		2	26	J	۲ ک	3	TC	26	1	<u>بر</u> کر	9	IC	26	J	26		25	07	IC	56	TC	26	Ę	2 2		IC	56	Ę	2 %	e CPT	Reserved 1 If values establishe	The b codes 9 Medica
(c) Te?	HCPCS	74181	74181	74181	74182	74182	74183	74183	74183	74185	74185	74190	74190	74190	74210	74210	74220	74220	74220	74230	74230	74235	74235	74240	74240	74240	74241	74241	74245	74245	74246	74246	74246	74247	74247	14741		
Mal- Dractice																XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	2 XXX 8 XXX						XXX	XXX	XXX	YYY	XXX		for CPT
Facility	RVUs ^{2,3}	NA	Y.	2 4								90	Ö	0.13	0.13	0.01	0.0	0.00	0.01	0.0	0.01	0.02	0.00	0.02	0.00	0.0	0.0	0.0	0.0	0.0	0.10	0.00	0.09	0.15	0.0	0.14 bts	ee ee	ر اق کے
Non- Facility or				o z	. A	99.0	NA	NA.	0.44	K	NA 0.50															0.10 0.0 NA 0.0				0.39 0.00			0.43 0.09		NA 0.01	U.58 U.14 iion. All Rights	values have been	ted in the RVUs I the files used for
	RVUs ^{2,3}	8.62		0.50 0.5									N.A.	99.0	NA	A S	NA N	N.	0.05		0.07	NA	NA	NA NA	ΝΆ		NA	0.36	Y :		N.	N.A	0.43		KN C	0.14 0.28 0.14 lical Association. All Rights	te that these values have been edicare payment.	a is not reflected in the RVUs i reflected in the files used for
Physic clan			8.12		9.66	0.66	7.70	7.26	0.44		0.73	9.88 NA	9.22 NA	99.0 99.0	8.71 NA	A S	0.41 NA	0.36 NA	0.05 0.05	Y Z	0.07 0.07	0.72 NA	0.64 NA	NA NA	0.78 NA	0.10 NA	3.17 NA	0.36 0.36	5.12 NA	0.39	7.02 NA	6.59 NA	0.43 0.43	7.27 NA	6.70 NA	1,90 0.58 0.58 0.14 American Medical Association. All Rights	ioare, please note that these values have been not used for Medicare payment.	c demonstration is not reflected in the RVUs ion will only be reflected in the files used for
Physi- clan was		1.62	0.00 8.12	0.50	0.00	2.15 0.66	7.70	0.00 7.26	1.35 0.44	1.62 8.25	0.73	ye 2.15 9.88 NA	0.00 9.22 NA	2.15 0.66 0.66	1.82 8.71 NA	0.00 8.16 NA	0.41 NA	0.00 0.36 NA	0.18 0.05 0.05	0.71 NA	0.23 0.07 0.07	0.27 0.72 NA	0.00 0.64 NA	0.06 0.87 NA	0.00 0.78 NA	0.10 0.10 3.53 NA	0.00 3.17 NA	re 1.19 0.36 0.36	1.27 5.12 NA	0.39 0.39	w/dye 1.40 7.02 NA	6.59 NA	1.40 0.43 0.43	1.90 7.27 NA	0.00 6.70 NA	Ct angio abdom w/o & w/dye 1,90 0.58 0.14 descriptions only are copyright 2009 American Medical Association. All Rights	Rected for codes not payable by Medicare, please note that these values have been coursesy to the general public and are not used for Medicare payment.	urality reduction from the chiropractic demonstration is not reflected in the RVUs i 941, and 98942. The required reduction will only be reflected in the files used for nt.
Physical clans clans and clans where	Work RVUs ^{2,3}	1.62	Mri lower extremity w/dye 0.00 8.12	1.62 0.50	Mri lwr extremity w/o&w/dve 0.00 9.96	Mri lwr extremity w/o&w/dye 2.15 0.66	Mri jnt of lwr extre w/o dye 1.35 7.70	Mri jnt of lwr extre w/o dye 0.00 7.26	Mri jnt of lwr extre w/o dye 1.35 0.44	Mri joint of lwr extr w/dye 1.62 8.25	Mri joint of lwr extr w/dye 0.00 (7.73	1.02 0.32 0.32 2.15 9.88 NA	Mri joint lwr extr w/o&w/dye 0.00 9.22 NA	Mri joint lwr extr w/o&w/dye 2.15 0.66 0.66	1.82 8.71 NA	Mr ang lwr ext w or w/o dye 0.00 8.16 NA	0.18 0.41 NA	X-ray exam of abdomen 0.00 0.36 NA	X-ray exam of abdomen 0.18 0.05 0.05	X-ray exam of abdomen 0.23 0.71 NA	0.23 0.07 0.07	X-ray exam of abdomen 0.27 0.72 NA	X-ray exam of abdomen 0.00 0.64 NA	0.27 0.08 0.08 men 0.32 0.87 NA	0.00 0.78 NA	odomen 0.32 0.10 0.10	Ct abdomen w/o dye 0.00 3.17 NA	re 1.19 0.36 0.36	1.27 5.12 NA	0.00 4.73 NA 1.27 0.39 0.39	w/dye 1.40 7.02 NA	0.00 6.59 NA	1.40 0.43 0.43	Ctangio abdom w/o & w/dye 1.90 7.27 NA	0.00 6.70 NA	A Cx angio abdom w/o & w/dye 1,90 0.58 0.14 coles and descriptions only are copyright 2009 American Medical Association. All Rights	ed. us are reflected for codes not payable by Medicare, please note that these values have been thed as a courtesy to the general public and are not used for Medicare payment.	uudget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs i 18940, 98941, and 98942. The required reduction will only be reflected in the files used for re payment.
	Nork Description RVUs ^{2,3}	A Mri lower extremity w/dye 1.62	A Mri lower extremity w/dye 0.00 8.12	Mri lower extremity w/dye 1.62 0.50	A Mri lwr extremity w/o&w/dye 0.00 9.96	Mri lwr extremity w/o&w/dye 2.15 0.66	Mri jnt of lwr extre w/o dye 1.35 7.70	A Mri jut of lwr extre w/o dye 0.00 7.26	Mri jnt of lwr extre w/o dye 1.35 0.44	A Mri joint of lwr extr w/dye 1.62 8.25	Mri joint of lwr extr w/dye 0.00 (7.73	A Mri joint lwr extr w/o&w/dye 2.15 9.88 NA	Mri joint lwr extr w/o&w/dye 0.00 9.22 NA	Mri joint lwr extr w/o&w/dye 2.15 0.66 0.66	R Mr ang lwr ext w or w/o dye 1.82 8.71 NA	Mr ang lwr ext w or w/o dye 0.00 8.16 NA	K Mr ang 1wr ext w or w/o dye 1.82 0.55 0.55 A X-rav exam of abdomen 0.18 0.41 NA	X-ray exam of abdomen 0.00 0.36 NA	X-ray exam of abdomen 0.18 0.05 0.05	X-ray exam of abdomen 0.23 0.71 NA	A X-ray exam of abdomen 0.23 0.07 0.07	A X-ray exam of abdomen 0.27 0.72 NA	A X-ray exam of abdomen 0.00 0.64 NA	X-ray exam of abdomen 0.27 0.08 0.08 X-ray exam series, abdomen 0.32 0.87 NA	A X-ray exam series, abdomen 0.00 0.78 NA	X-ray exam series, abdomen 0.32 0.10 0.10	Ct abdomen w/o dye 0.00 3.17 NA	re 1.19 0.36 0.36	A Ct abdomen w/dye 1.27 5.12 NA	0.00 4.73 NA 1.27 0.39 0.39	A Ct abdomen w/o & w/dye 1.40 7.02 NA	A Ct abdomen w/o & w/dye 0.00 6.59 NA	Ct abdomen w/o & w/dye 1.40 0.43 0.43	A Ctangio abdom w/o & w/dye 1.90 7.27 NA	Ct angro abdom w/o & w/dye 0.00 0.70 NA	A Ct angio abdom w/o & w/dye 1,90 0.58 0.58 0.58 codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserve to the control of the contro	³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Mediciar payment.

Physic Non- cian Facility Facility Mat- Work PE PF Practice Work 22 min 23 min	RVUe" RVUe" RVUe" F	000 AN AN 000	0.00 NA NA 0.00	0.70 0.23 0.03	0,00 NA NA 0,00	0.00 NA NA 0.00	0.70 0.23 0.23 0.05	0.00 NA NA 0.00	0.00 NA NA 0.00	0.90 0.29 0.06	0.00 NA NA 0.00	0.00 NA NA 0.00	0,54 0.17 0.17 0.04	0.00 NA NA 0.00	0.00 NA NA 0.00	0.76 0.25 0.25 0.05	0.00 NA NA 0.00	0.00 NA NA 0.00	0.54 0.22 0.22 0.04	0.00 NA NA 0.00	0.00 NA NA 0.00	0.88 0.26 0.26	0.49 2.27 NA 0.04	0.00 2.12 NA 0.00	0.09 0.13 0.03	1.49 2.29 NA 1.000 2.13 NA	0.49 0.15 0.15 0.03	t 0.49 2.87 NA	t 0.00 2.72 NA 0.00	0.49 0.15 0.15 0.03	ary tract 0.00 NA NA 0.00 XXX	0.36 0.11 0.11 0.03	: 0.00 NA NA 0.00	0.00 NA NA 0.00	0.36 0.11 0.11 0.03	0.32 1.70 NA 0.02	0.00 NA 0.00	0.32 0.10 0.10 0.02	0.38 1.75 NA 0.03	0.00 NA 0.00	Hract 0.38 0.13 0.13 0.03 XXX	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	teserved. If values are reflected for codes not navable by Medicare, please note that these values have been	istablished as a courtesy to the general public and are not used for Medicare payment.	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT index 00040, 00041, and 00042. The enquired enduction will only be adjusted in the files used for	ובלמוובת ובמתרונסו בנוו כמול כר ורווכבנית זו מדי וווכן מסרה ייי
		A-ray one duct endoscopy	A-ray one duct endoscopy	X-ray bile duct endoscopy	X-ray for pancreas endoscopy	X-ray for pancreas endoscopy	X-ray for pancreas endoscopy	X-ray bile/panc endoscopy	X-ray bile/panc endoscopy	X-ray bile/panc endoscopy	X-ray guide for GI tube	X-ray guide for GI tube	X-ray guide for GI tube	X-ray guide, intestinal tube	X-ray guide, intestinal tube	X-ray guide, intestinal tube	X-ray guide, Gl dilation	X-ray guide, GI dilation	X-ray guide, Gl dilation	X-ray, bile duct dilation	X-ray, bile duct dilation	X-ray, bile duct dilation	Contrst x-ray, urinary traci	Contrst x-ray, urmary tract	Contrst x-ray, urmary traci	Control x-ray, unmary tract	Contrat x-ray, urinary trac	Contrst x-ray, urinary traci	Contrst x-ray, urinary tract	Coutrst x-ray, urmary tract	Control x-ray, urmary tract	Control x-ray, urinary traci	Contrst x-ray, urinary tract	Contrst x-ray, urinary traci	Contrst x-ray, urinary tract	Contrast x-ray, bladder	Contrast x-ray, bladder	Contrast x-ray, bladder	X-ray, male genital tract	X-ray, male genital tract	X-ray, male genital tract	d descriptions only ar	reflected for codes not	a courtesy to the gener	entrality reduction from	0341, 4444 70774
	ಹ							ပ	-	₹	Ç	0	¥	ن	ن .	¥	O	0		ပ	0		Α.			4 4	. ∢	ν.	Y Y	∀ (ں ر ر	<	O	0	¥	V	∢ .	≪.	∢ .	4	¥	T codes an	Reserved.	bished as	e budget n	Oucs 70740, 7074
CPT ⁽³⁾	HCPCS Mod	•		4328 26		74329 TC		74330	•	74330 26	74340		14340 26	14355		74355 26	14360	74360 TC			74363 TC		74400		74400 26	74410 TC	74410 26			74415 26	74420 74420 Tr	14420 26	14425	74425 TC			74430 TC			4440 IC	4440 26	ڻ ر	Rese	estal	Ţ,	3
	Global	AAA	YYY	xxx	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	xxx	xxx	XXX	xxx	XXX	xxx	XXX	XXX	XXX	XXX	XXX	XXX	XXX	xxx	XXX	XXX	727	727	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				T	
Mal- Practice	RVUs.	00:0	0.00	0.06	0.03	0.00	0.03	0.05	00.0	0.05	0.0	0.00	0.03	0.05	0.00	0.05	0.07	0.00	0.07	60.0	0.01	60.0	0.02	0.00	0.02	0.0	0.01	0.00	00:0	0.03	00:0	0.02	000	0.00	0.03	0.04	0.00	0.04	0.1	0.00	0.11	ights	hopen .		reflected in the RVUs for CPT	בם זכו
Facility PE	RVUs ^{2,}	ď ;	Y.	0.28	Y Y	N V	0.14	Z	N.	0.21	NA A	NA	0.15	NA	N A	0.21	N A	Y Y	0.30	ΝĄ	NA	0.63	Y.	ď.	0.10	K Z	0.07	N A	NA	0.11	0.00	0.07	NA	NA	0.13	Y V	Y.	0.16	ď ;	A'N	0.21	tion. All R	velies have	payment.	cted in the I	UIC AIRCS US
Non- Facility PE	RVUs.	5.84	3.01	0.28	2.22	2.08	0.14	9.05	8.82	0.21	7.53	7.38	0.15	3.20	2.99	0.21	4,43	4.13	0.30	3.19	2.56	0.63	4	1.34	0.10	1.50	0.07	Ϋ́	N.	0.11	K Z	0.07	NA NA	NA	0.13	134	1.18	0.16	2.08	1.87	0.21	ical Associa	o that these	e mat urest edicare payr	is not refle	relicered an
Physi- cian Work	RVUs.	0.91	00:00	16:0	0.47	0.00	0.47	0.69	0.00	0.69	0.50	0.00	0.50	69:0	00'0	0.69	0.99	00'0	0.99	2.02	0.00	2.02	0.32	00:00	0.32	0.20	0.00	0.00	00:0	0.36	0.00	0.21	0.00	0.00	0.42	0.54	0.00	0.54	0.70	0.00	0.70	2009 American Mec	Madicara niesse no	fare not used for M	ractic demonstration	duction will only on
	Description	Contrst x-ray uppr gr tract	contrst x-ray uppr gi tract	Contrst x-ray uppr gi tract	X-ray exam of small bowel	K-ray exam of small bowel	X-ray exam of small bowel	X-ray exam of small bowel	X-ray exam of small bowel	X-ray exam of small bowei	X-ray exam of small bowel	X-ray exam of small bowel	X-ray exam of small bowel	Contrast x-ray exam of colon	Contrast x-ray, galibladder	Contrast x-ray, galibladder	Contrast x-ray, gallbladder	Contrast x-rays, galibladder	Contrast x-rays callbladder	X-ray bile ducts/pancreas	X-ray bile ducts/pancreas	X-ray bile ducts/pancreas	X-rays at surgery add-on	X-rays at surgery add-on	X-ray bile ducts/pancreas	X-ray bile ducts/pancreas	X-ray bile ducts/pancreas	Contrast x-ray of bile ducts	Contrast x-ray of bile ducts	Contrast x-ray of bile ducts	X-ray bile stone removal	X-ray bile stone removal	X-ray bile stone removal	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. ? If colors are reflected for codes not receible by Medicare alease note that these values have been	It values are reflected for codes not payable by Memoare, please note man established as a courtesy to the general public and are not used for Medicare	The budget neutrality reduction from the chiropractic demonstration is not	codes y8940, y8941, and y8y42. The required reduction will only be reflected in the files used for								
		Contrat	Contrs	Contr	X-ray	×	×	×	×	×	×	×	×	Ŭ	ŏ	0	_																					_				흳	Š	至草	[:	÷,
	Status	A Contrst x	_	A Contr	A X-ra)	,	A X-ra	.,	•					_	Ī	_	Ū	Ą	¥	٧	٧	٧	4	∢ ·	∢ .	∢ <	< ∢	; O	Ç	¥.	Ų (· «	ن :	၁	٧	K	٧	•			¥	odes and de	d.	res are reuted ted as a court	dget neutral	0240, 78541,
	Mod Status	∢ '	<	_	_	Κ		.,	₹		<		<	<	Ī	_	Α		26 A	V	TC A	26 A			26 A	۲ ·			TC C	26 A	ں ں پ			TC C	26 A		TC A	٠ ٧	¥	¥		' CPT codes and de	Reserved.	established as a cour	The budget neutral	codes 98940, 98941,

Wod	Status	Description X.rav.evam of penic	Physical clan Work RVUs ²³	Non- Facility PE RVUs ^{2,3}	Facility PE RVUs ²³	Mat- Practice RVUs ^{2.3,4}	Global XXX	CPT ¹³ HCPCS Mod	ភ	Description Cardiac mi flow/vel/trace	Physician Work RVUs ^{2,3}	Facility PE RVUs ^{2,3} 11.98	Facility PE RVUs ^{2,3} NA	Mal- Practice RVUs ^{2,1,4}	Global
) U	X-ray exam of penis	00.0	Y Y	N A	0.00	XX		z	Cardiac mri flow/vel/stress	00'0	10.89	N N	0.01	XX
	∢	X-ray exam of penis	1.14	0.37	0.37	80'0	xxx	75560 26		Cardiac mri flow/vel/stress	3.00	60:1	1.09	0.15	XXX
	ပ ၊	X-ray, urethra/bladder	0.00	V X	Y.	0.00	XXX		∢ ·	Cardiac mri for morph w/dye	2.60	8.63	Y :	0.15	XX
	ပ •	X-ray, urethra/bladder	0.00	Z S	Y S	000	XXX	75561 1C	< ₹	Cardiac inn for morph w/dye	0.00	08.7	V S	0.0	X
	< <	X-ray, ureima olaquer X-ray urethra/bladder	0.33	1.87	O. IO	0.02	XXX	07 19957	ξ 2	Cardiac uni for morph w/dye	2.86	11 71	G A	0.15	XXX
	. 4	X-ray, urethra/bladder	0.00	1.71	N Y	000	XXX		Z	Card mri flow/vel w/dye	0.00	10.66	Ϋ́	0.01	XXX
	₹	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	XXX	75562 26	Z	Card mri flow/vel w/dye	2.86	1.04	1.04	0.15	XXX
	Ų	X-ray exam of kidney lesion	00.0	N.	NA	0.00	XXX	75563	<	Card mri w/stress img & dye	3.00	10.40	Y.	0.17	XXX
	၁	X-ray exam of kidney lesion	0.00	NA	NA	00:0	XXX	75563 TC	4	Card mri w/stress img & dye	0.00	9.43	ΥZ	10.0	XXX
	¥	X-ray exam of kidney lesion	0.54	91.0	0.16	0.0	XXX		4	Card mri w/stress ing & dye	3.00	0.97	16.0	0.16	XXX
	∢ .	X-ray control, cath insert	0.54	1.32	¥:	0.04	XXX		Z;	Ht mri w/flo/vel/strs & dye	3.35	14.01	YZ ?	0.18	XX
	< ⋅	X-ray control, cath insert	0.00	1.16	Y.	0.00	XXX	75564 TC		Ht mri w/flo/vel/strs & dye	0.00	17.78	Υ.	0.01	XXX
	۷.	X-ray control, cath meer	4.5	0.10	0.10	0.0	XXX			Ht mn w/110/vet/strs & dye	5.33	77.1	77.1	71.0	<u> </u>
	ς •	A-ray control, cath insert	0.00	25.1	£ 2	4000	*			Contrast x-ray exam of aorta	64:0	4.32	V 2	000	۲ ×
	< <	A-ray control, cata insert	0.00	0.10	K 2	00.00	× × ×	75500 16		Contrast x-ray exam of sorts	0.00	0.16	71.0	0.00	X X X
	ζ 4	X-ray contot, cata assett	0.54	1.35	2.2	0.0	XXX			Contract viray exam of sorts	1.14	2.74	2 A	000	XXX
	< <	X-ray guide, GU dilation	0.00	1.19	Ϋ́	000	XXX			Contrast x-ray exam of aorta	0.00	1.87	×	000	XX
	<	X-ray guide, GU dilation	0.54	0.17	0.17	0.04	XXX	75605 26		Contrast x-ray exam of aorta	1.14	0.36	0.36	80:0	XXX
	4	X-ray measurement of pelvis	0.34	0.58	NA	0.02	XXX		A	Contrast x-ray exam of aorta	1.14	2.29	ΝA	0.11	XXX
	∢	X-ray measurement of pelvis	0.00	0.47	NA.	0.00	XX	75625 TC	¥.	Contrast x-ray exam of aorta	0.00	1.94	Y Z	000	XXX
	∢ .	X-ray measurement of pelvis	0.34	0.10	0.10	0.02	XXX	75625 26	∢ •	Contrast x-ray exam of aorta	4	0.35	0.35	0.0	XXX
	< <	X-ray, female gential tract	0.38	56.1	K	70:0	XXX		< ∢	X-ray aorta, leg artenes	6/-0	7.7	K Z	71.0	XX
	ξ <	V m. female gental tract	0.00	1.5	, C	000	\$XX	75630 36	< <	X-ray sorts for extense	00.0	1.50	25.0	10.0	XXX
	¢ 0	A-ray, remaie gennal uact X-ray, fallopian tube	000	NA NA	NA.	0.00	XXX		< <	Ct angio abdominal arteries	2.40	7.90	Š	0.16	XX
	O	X-ray, fallopian tube	0.00	NA	A	0.00	XXX		∢	Ct angio abdominal arteries	0.00	7.16	NA	10:0	XXX
	¥	X-ray, fallopian tube	19:0	61.0	61.0	0.04	XXX	75635 26	∢	Ct angio abdominal arteries	2.40	0.74	0.74	0.15	XXX
	၁	X-ray exam of perineum	0.00	NA	NA	0.00	XXX		٧	Artery x-rays, head & neck	1.49	2.41	NA	0.11	XXX
	C	X-ray exam of perineum	0.00	NA	Ϋ́	0.00	XXX	75650 TC	∢	Artery x-rays, head & neck	0.00	1.94	Ν	0.00	XXX
	٧	X-ray exam of permeum	0.62	0.19	0.19	0.0 40.5	XXX		< ⋅	Artery x-rays, head & neck	1.49	0.47	0.47	0.11	X
	∢ ·	Cardiac mri for morph	2.35	9.11	¥ ;	0.14 4.0	XXX		∢ ⋅	Artery x-rays, arm	1.31	2.93	V.	0.10	X X X
	< <	Cardiac mri for morph	0.00	0.74	A 7 0	0.01	XXX	75658 76	< <	Artery x-rays, arm	9.0	0.41	A 41	0.00	XXX
	(2	Cardiac mri flourivelocity	2,60	07.0	T AZ	210	XXX		< ₹	Artery x-rose head & noch	<u> </u>	2 80	Y.	0.07	XXX
	: Z	Cardiac uni flow/velocity	00.0	7.84	N N	0.01	XXX	75660 TC	< ∢	Artery x-rays, head & neck	000	2.45	, X	0.00	XX
	Z	Cardiac mri flow/velocity	2.60	0.95	0.95	0.13	XXX		∀	Artery x-rays, head & neck	1.31	4.0	0.44	90:0	XXX
	٧	Cardiac mri w/stress img	2.95	9.15	ΑN	0.18	XXX		¥	Artery x-rays, head & neck	1.66	3.57	ΝA	0.10	XXX
	٧	Cardiac mri w/stress img	0.00	8.20	N A	0.01	XXX	75662 TC	٧	Artery x-rays, head & neck	0.00	3.02	NA	0.00	XXX
	٧	Cardiac mri w/stress img	2.95	0.95	0.95	0.17	XXX	75662 26	¥	Artery x-rays, head & neck	1.66	0.56	0.56	60:0	XXX
	des and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Med	ical Associa	tion, All Ri	ghts		-	codes an	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Med	ical Associati	ion. All Rig	sts	
	Reserved. If values are refl	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	are, please not	e that these	values have	been		Reserved 2 If values	ved. slucs are n	leserved. If values are reflected for codes not payable by Medicare, please nore that these values have been	are, please not	e that these v	alues have b	cen	
	tget neut 940, 989.	established as a counce's from general phone and are not used to freeduce propriets. The budget neutrality reduction from the chiropractic demonstration is one reference in the RVUIs 69940, 98941, and 98942. The required reduction will only be reflected in the files used for	demonstration a will only be	is not refler reflected in	payment. reflected in the R ed in the files use	payment. reflected in the RVUs for CPT ed in the files used for		The codes	budget ne	Satabasses as a cources) to the general plant, and are not used to retender grayment. Satabasses as a cources) to the general plant, and are not used to retender grayment. Socies 98940, 89441, and 98942. The required reduction will only be reflected in the files used for	demonstration in will only be	is not reflect reflected in the	ed in the RV be files used	Us for CPT for	
• •	Medicare payment	Medicare payment. Clobert totals for malmostics BM is may not our due to rounding	to rounding					Medic	Medicare payment	Aedicare payment. Clobal totals for malmostics RVII's may not sum due to rounding	to rounding				
z	Mans Ion	Haip douce is to a may use over over	to tourning.						odt totano	of maipractice is a comment and and	to tournate.				

Reserved.

The five last are reflected for codes not payable by Medicare, please note that these values have been established as a countesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98041, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

	Global	X	XX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XX	777	777	ZZZ	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	X	X X X	XXX	X	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	X	XXX							
Mal- Practice	RVUs* 1.	0.10	0.00	0.09	0.12	0.00	0.12	0.08	0.00	0.08	0.19	0.00	0.18	0.03	0.00	0.03	0.13	10.0	0.12	0.00	0.00	0.13	0.00	0.00	0.08	00.0	90.0	000	000	800	0.0	000	0.04	00:0	0.00	80.0	0.05	0.00	0.05	0.08	0.00	80.0	phts		peen	VUs for CPT	for		
Facility	RVUs*	K :	X Y	0.39	X.	NA	0.51	A A	NA	0.35	NA	NA	0.35	1.58	1.47	0.11	K.	Ϋ́	0.57	NA	××	0.30	ΥZ	Y S	0.30	< -Z	50.0	0.2 AN	S Z	95.0	NA N	N A	0.15	NA	Z	0.34	Y.	NA	0.22	ΥZ	X Y	0.32	tion. All Rig		values have	sted in the R	the files used		
Non- Facility PE	RVUs.	2.20	1.81	0.39	2.57	5.06	0.51	2.54	2.19	0.35	2.71	2.36	0.35	1.58	1.47	0.11	2.39	1.82	0.57	N.	N.A	0.30	Z,	Z :	0.36	¥	250	(2.0 4.N	Y V	98.0	45	1.30	0.15	NA	ΝA	0.34	1.94	1.71	0.22	2.30	1.97	0.32	lical Associa		te that these	is not reflec	reflected in		
Physi- cian Work	RVUs	1.31	0.00	1.31	1,66	0.00	1.66	1.14	0.00	1,14	1.14	0.00	1.14	0.36	0.00	0.36	1.84	00:0	1.84	0.00	0.00	0.81	0.00	0.00	7.1.	900	200	0.00	000	1 17	0.47	000	0.47	0.00	0.00	1.14	0.70	0.00	0.70	1.06	0.00	1.06	merican Me		are, please no princed for M	demonstration	a will only be		o rounding.
	Description	Artery x-rays, lung	Artery x-rays, lung	Artery x-rays, lung	Artery x-rays, lungs	Artery x-rays, lungs	Artery x-rays, lungs	Artery x-rays, lung	Artery x-rays, lung	Artery x-rays, lung	Artery x-rays, chest	Artery x-rays, chest	Artery x-rays, chest	Artery x-ray, each vessel	Artery x-ray, each vessel	Artery x-ray, each vessel	Visualize A-V shunt	Visualize A-V shunt	Visualize A-V shunt	Lymph vessel x-ray, arm/leg	Lymph vessel x-ray, arm/leg	Lymph vessel x-ray, arm/leg	Lymph vessel x-ray,arms/legs	Lymph vessel x-ray,arms/legs	Lymph vessel x-ray,arms/legs	Lymph vessel x-ray, trunk	Lymph Yessei A-lay, umm	Lymph vessel x-ray, trunk	Lymph vessel x-lay, a mix	Lymph vessel x-1dy, unin	Nonvaccular shint x-ray	Nonvascular shunt, x-ray	Nonvascular shunt, x-ray	Vein x-ray, spleen/liver	Vein x-ray, spleen/liver	Vein x-ray, spleen/liver	Vein x-ray, arm/leg	Vein x-ray, arm/leg	Vein x-ray, arm/leg	Vein x-ray, arms/legs	Vein x-ray, arms/legs	Vein x-ray, arms/legs	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		if values are reflected for codes not payable by Medicare, please note that these values have been senablished on a contract to the contract may made to the contract to the c	estabilistical as a countest to use general production and are not used for executed payment. The budget neutrality reduction from the chiramactic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	r maipractice K∨∪s may not sum cue i
	Status	ď	A	ĸ	A	Ą	¥	Ą	٧	A	¥	Ą	¥	¥	*	¥	¥	K	A	Ç	ပ	¥	ပ	ပ	₹ () ر	> د	£ () C	⊳ د	< ⊲	: ∢	: ∢	Ų	ပ	*	Ą	Ą	Ą	¥	¥	¥	codes and	ed.	lues are ref	nidoet neut	98940, 989	are paymer	al totais to
	Wod		IC	56		TC	56		IC	56		TC	56		IC	26		JC	56		TC	56		C	26	Ç	, ,	07	Ţ	۲ ۶	07	TC	26	;	TC	26		TC	26		ЗС	56	CPT	Reserved	F If va	3 The	codes	Medic	505
CPT ¹³ 1	HCPCS	75741	75741	75741	75743	75743	75743	75746	75746	75746	75756	75756	75756	75774	75774	75774	75790	75790	75790	75801	75801	75801	75803	75803	75803	75905	20027	75807	70957	75807	75800	75809	75809	75810	75810	75810	75820	75820	75820	75822	75822	75822							
	Global	XXX	XXX	XXX	XXX	xxx	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	X X	X X X	X	X X	X X X	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX							
Mal- Practice	•																																XXX 600		0000 XXX						000 XXX				een	Ale for CPT	for		
Facility Mat- PE Practice	RVUs 23.	0.12	000	0.12		0.00	0.11	0.12	000	0.12	0.12	000	0.12	01.0	00'0	0.10	0.11	0.01	0.11	0.07	000		0.11	0.00	0.11	80:0	0.00	0.08	0.08	0.00	0.00	000		900	000		0.07	0.00	90:0		00'0			ì	values have been	nent. Had in the DVI is for CDT	the files used for		
Facility	3 RVUs23 RVUs234 C	.10 NA 0.12	NA 0.00	0.44 0.12	85 NA 0.12	NA 0.00	0.54 0.11	NA 0.12	NA 0.00	0.43 0.12	NA 0.12	000	0.54 0.12	01.0	43 NA 0.00	0,43 0.10	NA 0.11	NA 0.01	71 0.71 0.11	83 NA 0.07	NA 0.00	0.07	NA 0.11	NA 0.00	0.41 0.11	80:0	10 NA 0.00	0.36 0.08	NA 0000	NA 0.00	NA 0.10	000 VN	0.34 0.09	57 NA 0.06	000 AN 0.00	0.05	NA 0.07	NA 0.00	0.44 0.06	NA 0.08	NA 0.00	0.35 0.07		,	ote that these values have been	redicate payment.	e reflected in the files used for		
Facility	RVUs'3 RVUs23 RVUs234	3.10 NA 0.12	.66 NA 0.00	44 0.44 0.12	3.85 NA 0.12	3.31 NA 0.00	0.54 0.54 0.11	NA 0.12	2.40 NA 0.00	0.43 0.12	3.32 NA 0.12	NA 0.00	0.54 0.54 0.12	2.86 NA 0.10	2.43 NA 0.00	0.43 0.43 0.10	3.20 NA 0.11	2.49 NA 0.01	0.71 0.71 0.11	2.83 NA 0.07	2.47 NA 0.00	0.36 0.36 0.07	3.57 NA 0.11	3,16 NA 0.00	0.41 0.41 0.11	2.52 NA 0.08	0.10 NA 0.00	0.36 0.36 0.08	NA 0000	2.06 NA 0.00	NA 0.10	000 VN 7/:7	0.34 0.34 0.09	2 57 NA 0.06	2.19 NA 0.00	0.38 0.38 0.05	3.37 NA 0.07	2.93 NA 0.00	0.44 0.44 0.06	NA 0.08	NA 0.00	0.35 0.35 0.07		ŀ	are, please note that these values have been	tot used for integrate payment.	n will only be reflected in the files used for		to rounding.
Non- Facility Facility PE PE	Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} C	3.10 NA 0.12	2.66 NA 0.00	Artery x-rays, bead & neck 1.31 0.44 0.12	Artery x-rays, head & neck 1.66 3.85 NA 0.12	Artery x-rays, head & neck 0.00 3.31 NA 0.00	Artery x-rays, head & neck 1.66 0.54 0.54 0.11	Artery x-rays, neck 1.31 2.83 NA 0.12	Artery x-rays, neck 0.00 2.40 NA 0.00	Artery x-rays, neck 1.31 0.43 0.43 0.12	Artery x-rays, neck 1.66 3.32 NA 0.12	Artery x-rays, neck 0.00 2.78 NA 0.00	Artery x-rays, neck 1.66 0.54 0.54 0.12	Artery x-rays, spine 1.31 2.86 NA 0.10	Artery x-rays, spine 0.00 2.43 NA 0.00	Artery x-rays, spine 1.31 0.43 0.43 0.10	Artery x-rays, spine 2.18 3.20 NA 0.11	Artery x-rays, spine 0.00 2.49 NA 0.01	Artery x-rays spine 2.18 0.71 0.11	Artery x-rays, arm/lep 1.14 2.83 NA 0.07	Artery x-rays, arm/leg 0.00 2.47 NA 0.00	Artery x-rays, arm/leg 1.14 0.36 0.36 0.07	Artery x-rays, arms/legs 1.31 3.57 NA 0.11	Artery x-rays, arms/legs 0.00 3.16 NA 0.00	Artery x-rays, arms/legs 1.31 0.41 0.11	Artery x-rays, kidney 1.14 2.52 NA 0.08	Artery x-rays, kidney 0.00 2.10 INA 0.00	Artery x-rays, kidney 1.14 0.36 0.36 0.08	Artery x-rays, kidneys 1.49 5.13 NA 0.08	Artery x-rays, kidneys 0.00 2.00 NA 0.00	Artery x-rays, kidneys 1.49 0.49 0.06	Artery x-rays, abdomen 1.14 2.72 (17 0.10	Artery x-rays, abdomen (14 0.34 0.09	Artery vrays adrenal oland 114 2.57 NA 0.06	Artery x-rays, adrenal pland 0.00 2.19 NA 0.00	Artery x-rays, adrenal gland 1.14 0.38 0.38 0.05	Artery x-rays, adrenals 1.31 3.37 NA 0.07	Artery x-rays, adrenals 0.00 2.93 NA 0.00	Artery x-rays, adrenals 1.31 0.44 0.06	Artery x-rays, pelvis 1.14 2.70 NA 0.08	Artery x-rays, pelvis 0.00 2.35 NA 0.00	Artery x-rays, pelvis 1.14 0.35 0.35 0.07			e reflected for codes not payable by Medicare, please note that these values have been	is a courtesy to the general public and are not used for Medicare payment. ———————————————————————————————————	i gentratify reduction from the canopractic ventrous arrow is not reflected in the files used for . 98941, and 98942. The required reduction will only be reflected in the files used for	yment.	is for malpractice RVUs may not sum due to rounding.
Non- Facility Facility PE PE	Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} C	1.31 3.10 NA 0.12	0.00 2.66 NA 0.00	A Arrery x-rays, head & neck 1.31 0.44 0.44 0.12	A Artery x-rays, bead & neck 1.66 3.85 NA 0.12	A Artery x-rays, head & neck 0.00 3.31 NA 0.00	A Artery x-rays, head & neck 1.66 0.54 0.54 0.11	Artery x-rays, neck 1.31 2.83 NA 0.12	A Artery x-rays, neck 0.00 2.40 NA 0.00	A Artery x-rays, neck 1.31 0.43 0.43 0.12	A Arrery x-rays, neck 1.66 3.32 NA 0.12	A Artery x-rays, neck 0.00 2.78 NA 0.00	A Artery x-rays, neck 1.66 0.54 0.54 0.12	A Artery x-rays, spine 1.31 2.86 NA 0.10	A Artery x-rays, spine 0.00 2.43 NA 0.00	A Artery x-rays, spine 1.31 0.43 0.43 0.10	A Artery x-rays, spine 2.18 3.20 NA 0.11	A Arrery s-rays snine 0.00 2.49 NA 0.01	A Artery x-rays, spine 2.18 0.71 0.71 0.11	A Arrery x-rays, arm/lee 1.14 2.83 NA 0.07	A Artery x-rays, arm/leg 0.00 2.47 NA 0.00	A Artery x-rays, arm/leg 1.14 0.36 0.36 0.07	Artery x-rays, arms/legs 1.31 3.57 NA 0.11	A Artery x-rays, arms/legs 0.00 3.16 NA 0.00	A Artery x-rays, arms/legs 1.31 0.41 0.41 0.11	A Artery x-rays, kidney 1.14 2.52 NA 0.08	A Artery x-rays, kidney 0.00 2.10 NA 0.00	A Artery x-rays, kidney 1.14 0.30 0.35 0.08	A Artery x-rays, kidneys 1.49 5.15 NA 0.00	A Artery x-rays, kidneys U.00 2.00 NA U.00	A Artery x-rays, kidneys 1.49 0.49 0.00	A Attent abdomen 0.00 2.12 iv. 0.10	A Arieny virase abdomen (14 0.34 0.34 0.09	A Artery e-rays advents oland 1.14 2.57 NA 0.06	A Arreny x-rays, adrenal gland 0.00 2.19 NA 0.00	A Artery x-rays, adrenal gland 1.14 0.38 0.38 0.05	A Artery x-rays, adrenals 1.31 3.37 NA 0.07	A Artery x-rays, adrenals 0.00 2.93 NA 0.00	A Artery x-rays, adrenals 1.31 0.44 0.06	1.14 2.70 NA 0.08	A Artery x-rays, pelvis 0.00 2.35 NA 0.00	A Artery x-rays, pelvis 1.14 0.35 0.35 0.07		erved	values are reflected for codes not payable by Medicare, please note that these values have been	blished as a courtesy to the general public and are not used for Medicare payment.	he bugget neutativy reduction notificate components because in the files used for expected in the files used for	licare payment.	obal totals for malpractice RVUs may not sum due to rounding.
Non- Facility Facility PE PE	Mod Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} C	A Artery x-rays, head & neck 1.31 3.10 NA 0.12	0.00 2.66 NA 0.00	26 A Artery x-rays, head & neck 1.31 0.44 0.44 0.12	A Artery x-rays, head & neck 1.66 3.85 NA 0.12	TC A Artery x-rays, head & neck 0.00 3.31 NA 0.00	26 A Artery x-rays, head & neck 1.66 0.54 0.54 0.11	A Artery x-rays, neck 1.31 2.83 NA 0.12	TC A Artery x-rays, neck 0.00 2.40 NA 0.00	26 A Artery x-rays, neck 1.31 0.43 0.43 0.12	A Artery x-rays, neck 1.66 3.32 NA 0.12	TC A Artery x-rays, neck 0.00 2.78 NA 0.00	26 A Artery x-rays, neck 1.66 0.54 0.54 0.12	A Arrery x-rays, spine 1.31 2.86 NA 0.10	TC A Artery x-rays, spine 0.00 2.43 NA 0.00	26 A Arrery 8-rays, spine 1.31 0.43 0.43 0.10	A Artery x-rays, spine 2.18 3.20 NA 0.11	TC A Arreys, sinite 0.00 2.49 NA 0.01	26 A Artery x-rays, spine 2.18 0.71 0.71 0.11	A Ariery x-rays, arm/leg 1.14 2.83 NA 0.07	TC A Artery x-rays, arm/leg 0.00 2.47 NA 0.00	26 A Artery x-rays, arm/leg 1.14 0.36 0.36 0.07	Artery x-rays, arms/legs 1.31 3.57 NA 0.11	TC A Artery x-rays, arms/legs 0.00 3.16 NA 0.00	26 A Artery x-rays, arms/legs 1.31 0.41 0.41 0.11	A Artery x-rays, kidney 1.14 2.52 NA 0.08	1C A Artery x-rays, kidney 0.00 2.10 NA 0.00	26 A Artery x-rays, kidney 1.14 0.36 0.36 0.08	A Artery x-rays, kidneys 1.49 5.13 NA 0.00	TC A Arrery x-rays, kidneys 0.00 2.00 INA 0.00	26 A Artery x-rays, kidnicys 1.49 0.49 0.06	TC A Artery x-rays, abdomen 1.14 2.72 100 0.10	Artery x-rays, abdomen (14 0.34 0.09	A Artery x-rays adrenal cland 1.14 2.57 NA 0.06	TC A Arrery x-rave adrenal pland 0.00 2.19 NA 0.00	26 A Arriery x-rays, adrenal gland 1.14 0.38 0.38 0.05	A Ariety x-rays, adrenals 1.31 3.37 NA 0.07	TC A Artery x-rays, adrenals 0.00 2.93 NA 0.00	26 A Artery x-rays, adrenals 1.31 0.44 0.44 0.06	A Artery x-rays, pelvis 1.14 2.70 NA 0.08	A Artery x-rays, pelvis 0.00 2.35 NA 0.00	26 A Artery x-rays, pelvis 1.14 0.35 0.35 0.07	† CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved.	² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courfely to the general public and are not used for Miclaus payment.	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	⁴ Global totals for malpractice RVUs may not sum due to rounding.

CPT ^{1,3} /				Physician cian Work	Non- Facility PE	Facility PE	Mal- Practice	juden j	CPT ¹³	3	į	Description	Physi- cian Work	Non- Facility PE RVIs ^{2,3}	Facility PE RVUs ²³	Mal- Practics RV(1s ^{2.3,4}	Global
HCPCS	DO M	Status	_ '	80.4	8 6		900	XXX	75803	Ē	4	Venous sampling by catheter	0.54	1 95	×Z.	0.03	XX
57857	Ę	< -	Vein x-ray, numk	000	1 75	C 2	0.00	XXX	75893	Ţ	(∢	Venous sampling by catheter	0.00	1.78	NA	0.00	XXX
50057) <u>y</u>	< ⊲	Vein v-ray trunk	27.	25	0.34	60.0	XXX	75893	26	: ≺	Venous sampling by catheter	0.54	0.16	91.0	0.03	XXX
75827	07	< ∢	Vein x-ray, trums	1.14	2.21	N A	0.08	XXX	75894		ပ	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75827	IC	: <	Vein x-ray, chest	0.00	1.86	N.	0.00	XXX	75894	TC	Ç	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75827	56	V	Vem x-ray, chest	1.14	0.35	0.35	80:0	XXX	75894	26	٧	X-rays, transcath therapy	1.31	0.40	0.40	0.12	XX
75831	i	<	Vein x-ray, kidney	1.14	2.21	NA V	0,21	XXX	75896		ပ	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75831	TC	4	Vein x-ray, kidney	0.00	1.87	N.A	00:0	XXX	75896	C	ပ	X-rays, transcath therapy	0.00	NA	NA A	0.00	XXX
75831	56	<	Vein x-ray, kidney	1,14	0.34	0,34	0.20	XXX	75896	56	٧	X-rays, transcath therapy	1.31	0.41	0.41	0.12	XXX
75833		<	Vein x-ray, kidneys	1.49	2.76	NA	0.11	XXX	75898		၁	Follow-up angiography	0.00	NA	NA	00.0	XXX
75833	C	∢	Vein x-ray, kidneys	0.00	2.32	NA	000	XXX	75898	TC	ပ	Follow-up angiography	0.00	NA	Z,	000	XXX
75833	56	V	Vein x-ray, kidneys	1.49	0.44	0.44	0.10	XXX	75898	56	∢	Follow-up angiography	1.65	0.52	0.52	0.15	XXX
75840		Ą	Vein x-ray, adrenal gland	1.14	2.07	NA	0.21	XXX	75900		O ·	Intravascular cath exchange	0.00	Y ;	Y;	0.00	XXX
75840	C	¥	Vein x-ray, adrenal gland	0.00	1.76	NA VA	00.0	XXX	75900	72	ပ	Intravascular cath exchange	0.00	YZ Z	Y.	0.00	XXX
75840	76	¥	Vein x-ray, adrenal gland	1.14	0.31	0.31	0.20	XXX	75900	26	٧	Intravascular cath exchange	0.49	0.15	0.15	0.05	XX
75842		V	Vein x-ray, adrenal glands	1.49	2.71	NA	0.11	XXX	19657		¥	Remove cva device obstruct	0.49	3.89	NA	0.04	X
75842	C	<	Vein x-ray, adrenal glands	0.00	2.24	NA	00:0	XXX	75901	C	4	Remove cva device obstruct	0.00	3.74	A	0.00	XXX
75847	3,6	₹ ₹	Vein x-ray, adrenal glands	1.49	0.46	0.46	0.10	XXX	75901	56	¥	Remove eva device obstruct	0.49	0.15	0.15	0.04	XXX
75860	ì	: ≺	Vein x-ray, neck	1.14	2.17	N.	0.09	XXX	75902		Ą	Remove cva lunen obstruct	0.39	1.55	NA	0.05	XXX
75860	JC	· «	Vein x-ray, neck	0.00	1.81	NA	0.00	XXX	75902	TC	4	Remove eva lumen obstruct	0.00	1.43	NA	0.00	XX
75860	56	<	Vein x-ray, neck	1.14	0.36	0.36	60:0	XXX	75902	56	Ą	Remove cva lumen obstruct	0.39	0.12	0.12	0.04	XXX
75870		×	Vein x-ray, skuil	1.14	2.32	NA	80.0	XXX	75940		၁	X-ray placement, vein filter	0.00	NA	NA	00.0	XXX
75870	TC	*	Vein x-ray, skull	0.00	1.94	Ν	0.00	XXX	75940	IC	၁	X-ray placement, vein filter	0.00	ΝA	ΑN	0.00	XX
75870	56	¥	Vein x-ray, skull	1,14	0.38	0.38	80.0	XXX	75940	56	٧	X-ray placement, vein filter	0.54	91.0	0.16	0.05	XX
75872		٧	Vein x-ray, skull	1.14	4.62	NA	80.0	XXX	75945		ပ	Intravascular us	0.00	NA	NA	0.00	XXX
75872	TC	4	Vein x-ray, skull	0.00	4.09	NA	0.00	XXX	75945	J.C	ပ	Intravascular us	0.00	Ϋ́	A'A	0.00	XXX
75872	56	٧	Vein x-ray, skull	1.14	0.53	0.53	0.08	XXX	75945	56	٧	Intravascular us	0.40	0.12	0.12	0.05	XX
75880		٧	Vein x-ray, eye socket	0.70	2.03	ΝĄ	0.05	XXX	75946		ပ	Intravascular us add-on	0.00	NA NA	0.00	0.00	ZZZ
75880	IC	4	Vein x-ray, eye socket	00.00	181	NA	0.00	xxx	75946	TC	ပ	Intravascular us add-on	0.00	NA	0.00	00:0	777
75880	26	¥	Vein x-ray, eye socket	0.70	0.22	0.22	0.05	XXX	75946	76	∢	Intravascular us add-on	0.40	0.12	0.12	90:0	ZZZ
75885		¥	Vein x-ray, liver	1.44	2.27	NA	0.10	XXX	75952		ပ	Endovasc repair abdom aorta	0.00	NA	A	0.00	XX
75885	IC	¥	Vein x-ray, liver	0.00	1.84	NA	0.00	XXX	75952	C	၁	Endovasc repair abdom aorta	0.00	NA	NA.	0.00	X
75885	56	4	Vein x-ray, liver	1.4	0.43	0.43	0.10	XXX	75952	56	¥	Endovasc repair abdom aorta	4,49	1.36	1.36	99.0	X
75887		Ą	Vein x-ray, liver	1.44	2.35	NA	80'0	XXX	75953		ပ	Abdom aneurysm endovas rpr	0.00	Y.	Y.	0.00	XX
78887	TC	4	Vein x-ray, liver	0.00	1.90	NA	0.00	XXX	75953	TC :	ပ	Abdom aneurysm endovas rpr	0.00	Y ?	Y.	0.00	X
75887	56	A	Vein x-ray, liver	1.44	0.45	0.45	80.0	XXX	75953	56	∢	Abdom aneurysm endovas rpr	1.36	0.41	0,41	0.20	X
75889		K	Vein x-ray, liver	1.14	2.17	NA	80.0	XXX	75954		ပ	Iliac aneurysm endovas rpr	0.00	Z.	Z.	0.00	XX
75889	TC	٧	Vein x-ray, liver	0.00	1.83	NA	0.00	XXX	75954	C	ပ	lliac aneurysm endovas rpr	0.00	Y Z	Y.	0.00	X
75889	56	Ą	Vein x-ray, liver	1.14	0.34	0.34	0.08	XXX	75954	56	٧	Iliac aneurysm endovas rpr	2.25	89.0	89.0	0.32	XX
75891		٧	Vein x-ray, liver	1.14	2.17	ΝA	80.0	XXX	75956		၁	Xray, endovase thor ao repr	0.00	NA	NA	0.00	XX
75891	TC	4	Vein x-ray, liver	0.00	1.83	Ϋ́	0.00	XXX	75956	TC	ပ	Xray, endovase thor ao repr	0.00	Y.	Y.	0.00	XXX
75891	56	A	Vein x-ray, liver	1.14	0.34	0.34	80.0	XXX	75956	56	٧	Xray, endovase thor ao repr	7.00	2.07	2.07	1,10	XXX
	CPT	codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medic	al Associat	ion. All Rig	hts			CPT	odes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	cal Associati	on. All Rigl	ıts	
	Reserved.	eq.			•					Reserved	jd.	(eserved, 10101010101010101010	to a cooperate	y doct there y	ahar hana h	40	
	· If vali	ues are n	" If values are reflected for codes not payable by Medicare, please note that these values have occur- participal of a courteen to the canasal multic and are not used for Medicare payment	e, please note	that these v	atues nave t	xecu			establis	ies are reg hed as a c	It values are reflected for codes not payable by included by please note that these values as a courtesy to the general public and are not used for Medicare payment.	ne, prease non ot used for Me	dicare payme	attics nave o	3	
	The b	sucu as a rudget ne	The budget neutrality reduction from the chiropractic demonstration is not	monstration	s not reflect	ed in the R	reflected in the RVUs for CPT			The bi	ndget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	lemonstration	is not reflect	ed in the RV	Us for CPT	
	codes 9	codes 98940, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflect	will only be n	effected in t	ed in the files used for	tor			Medica	Medicare payment.	41, and 96942. The required reduction	i will only be i	n m papana	ne mes neen	<u> </u>	
	4 Globa	ate payar atrotak f	oreactate payment. Global totals for maloractice RVIIs may not sum due to rounding	rounding.						4 Globa	totals for	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				
	C. M. C.	at types	to mappeasses as a sense of the	- Comment								,	,				

CPT ^{1,3} /			;	Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice	3	CPT ¹³	3	į	a cipalita a care	Physi- cian Work	Non- Facility PE	Facility PE DVII-2-3	Mai- Practice	jado
HCPCS	Mod	Startus	Very and appears that as year	. 90 O	80 A	\$ Z	900	XXX	75980	5	A	Abscess drainage under x-ray	1.19	1.48	NA NA	80:0	XXX
15057	Ĺ,	ر ر	Xrav endovase ther as repr	000	ξ X	ξX	000	XXX	75989	TC	. Α	Abscess drainage under x-ray	0.00	1.12	ΝA	0.00	XXX
75957	2 %	> <	Xrav, endovase thor ao repr	6.00	1.77	1.77	0.93	XXX	15989	56	٧	Abscess drainage under x-ray	1.19	0.36	0.36	80.0	XXX
75958	ì	: O	Xray, place prox ext thor ao	0.00	NA	NA	0.00	XXX	78992		C	Atherectomy, x-ray exam	0.00	YZ Z	ΥN	0.00	XXX
75958	TC	O	Xray, place prox ext thor ao	0.00	NA	ΥZ	0.00	XXX	75992	TC	၁	Atherectomy, x-ray exam	0.00	Y.	Y.	0.00	XXX
75958	56	٧	Xray, place prox ext thor ao	4.00	1.17	1.17	0.62	XXX	75992	56	∢ :	Atherectomy, x-ray exam	0.54	0.17	0.17	60.0	XXX
75959		ပ	Xray, place dist ext thor ao	0.00	NA	Ϋ́	0.00	XXX	75993		ပ	Atherectomy, x-ray exam	000	۲ ; ک	YZ.	0.00	7777
75959	10	C	Xray, place dist ext thor ao	0.00	NA	ΝΑ	0.00	XXX	75993	2	U	Atherectomy, x-ray exam	0.00	KZ.	Ϋ́	0.00	777
75959	26	٧	Xray, place dist ext thor ao	3.50	0.95	0.95	0.63	XXX	75993	56	۷	Atherectomy, x-ray exam	0.36	0.11	0.11	0.04	777
75960		4	Transcath iv stent rs&i	0.82	1.72	Ϋ́	90'0	XXX	75994		၁	Atherectomy, x-ray exam	0.00	Y Z	Ϋ́	0.00	X
75960	JC	Ą	Transcath iv stent rs&i	0.00	1.46	Ϋ́Z	00'0	XXX	75994	C	ပ	Atherectomy, x-ray exam	0.00	Ϋ́	Ϋ́	0.00	XXX
75960	56	∢	Transcath iv stent rs&i	0.82	0.26	0.26	90.0	XXX	75994	56	4	Atherectomy, x-ray exam	1.31	0.31	0.31	0.10	XXX
75961		¥	Retrieval, broken catheter	4.24	3.52	Y Z	0.31	XXX	75995		ပ	Atherectomy, x-ray exam	0.00	ΥZ	ΝA	0.00	XX
75961	TC	K	Retrieval, broken catheter	0.00	2.24	ΥZ	0.01	XXX	75995	TC	ပ	Atherectomy, x-ray exam	00'0	Y.	NA	0.00	XX
75961	56	٧	Retrieval, broken catheter	4.24	1.28	1.28	0.29	XXX	78995	56	∢	Atherectomy, x-ray exam	1.31	0.44	0.44	0.07	XXX
75962		4	Repair arterial blockage	0.54	2.44	ΥN	0.04	XXX	15996		၁	Atherectomy, x-ray exam	0.00	Y Y	ΝA	0.00	777
75962	C	V	Repair arterial blockage	0.00	2.27	ΝĄ	0.00	XXX	12996	C	ပ	Atherectomy, x-ray exam	0.00	¥ Z	ΝA	0.00	ZZZ
75962	76	×	Repair arterial blockage	0.54	0.17	0.17	0.04	XXX	15996	56	¥	Atherectomy, x-ray exam	0.36	0.10	0.10	90.0	777
75964		٧	Repair artery blockage, each	0.36	1.47	1.47	0.04	ZZZ	76000		4	Fluoroscope examination	0.17	2.74	Y Z	0.02	XX
75964	C	V	Repair artery blockage, each	0.00	1.36	1.36	0.00	777	00092	2	٧	Fluoroscope examination	0.00	2.68	NA	0.00	XXX
75964	76	V	Repair artery blockage, each	0.36	0.11	0.11	0.04	ZZZ	00091	56	Ą	Fluoroscope examination	0.17	90:0	90.0	0.02	XXX
75966		¥.	Repair arterial blockage	1.31	2.68	ΥZ	60'0	XXX	10097		ပ	Fluoroscope exam, extensive	0.00	Ϋ́Α	NA A	0.00	XXX
75966	TC	¥	Repair arterial blockage	0.00	2.26	NA	0.00	XXX	10092	C	ပ	Fluoroscope exam, extensive	0.00	×z	Y.	0.00	XX
75966	56	¥	Repair arterial blockage	1.31	0.42	0.42	80.0	XXX	10091	56	Ą	Fluoroscope exam, extensive	0.67	0.24	0.24	0.07	XX
75968		<	Repair artery blockage, each	0.36	1.36	1.36	0.02	222	01092		¥	X-ray, nose to rectum	0.18	0.47	ΥN	0.01	XX
75968	IC	<	Repair artery blockage, each	0.00	1.24	1.24	00.0	222	01092	2	¥	X-ray, nose to rectum	0.00	0.42	NA	0.00	XX
75968	36	٧	Repair artery blockage, each	0.36	0.11	0.11	0.02	222	01092	56	¥	X-ray, nose to rectum	81.0	0.05	0.05	0.01	XX
75970		၁	Vascular biopsy	0.00	ΝĄ	¥ Z	00:0	XXX	16080		٧	X-ray exam of fistula	0.54	86.0	NA	0.03	X
75970	IC	O	Vascular biopsy	00'0	NA	NA	0.00	XXX	16080	IC	4	X-ray exam of fistula	0.00	0.82	Ν	0.00	XX
75970	26	٧	Vascular biopsy	0.83	0.25	0.25	90:0	XXX	16080	56	Ą	X-ray exam of fistula	0.54	0.16	0.16	0.03	X
75978		Ą	Repair venous blockage	0.54	2.52	Ϋ́Z	0.04	XXX	16098		Ą	X-ray exam, breast specimen	0.16	0.29	Y.	0.01	X
75978	C	٧	Repair venous blockage	0.00	2.35	Ϋ́	0.00	XXX	20098	CC	4	X-ray exam, breast specimen	0.00	0.24	N.	00'0	XXX
75978	56	V	Repair venous blockage	0.54	0.17	0.17	0.03	XXX	16098	56	Ą	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	XXX
75980		၁	Contrast xray exam bile duct	0.00	NA	₹ Z	0.00	XXX	00192		¥	X-ray exam of body section	0.58	3.46	Ψ.	0.05	XXX
75980	TC.	၀	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX	20192	22	٧	X-ray exam of body section	0.00	3.21	AN S	0.00	XX
75980	56	¥	Contrast xray exam bile duct	4	0.43	0.43	0.10	XXX	76100	56	∢	X-ray exam of body section	0.58	0.24	47.0	0.03	4
75982		၁	Contrast xray exam bile duct	0.00	NA	Ν	0.00	XXX	10192		4	Complex body section x-ray	0.58	5.23	Y.	70.0	X
75982	IC	Ç	Contrast xray exam bile duct	0.00	ΝA	Ϋ́	0.00	XXX	16101	2	¥.	Complex body section x-ray	0.00	4.92	¥ 2	0.0	<u> </u>
75982	70	¥	Contrast xray exam bile duct	1.44	0.43	0.43	0.11	XXX	10197	70	¥	Complex body section x-ray	0.58	0.32	0.32	0.01	5 5
75984		٧	Xray control catheter change	0.72	1.51	Ϋ́	0.05	XXX	76102	ę	۷.	Complex body section x-rays	0.58	797	Y S	70.0	X X X
75984	2	¥,	Xray control catheter change	0.00	1.29	V.	0.00	XXX	7010/	⊇ :	ď	Complex body section x-rays	0.00	07'	ξ.,	0.00	5 5
75984	26	¥	Xray control catheter change	0.72	0.22	0.22	0.05	XXX	76102	56	¥	Complex body section x-rays	0.58	0.34	0.34	0.02	XX
-	CPT co	odes and	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	ical Associa	ttion. All Ri	ghts			CPTed	des and o	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	cal Associati	on. All Righ	ts	
	Reserved.	Ġ.		-	7	_				Reserved.	1. om mofi	(eserved. If some one coffermed for anches not manable by Madihare Inlease note that these values have been	ston asseln en	a that thees ve	hiec have by	ę.	
	f value	es are rei	If values are reflected for codes not payable by Medicare, please note that the	tre, please no	te that these valued	these values have been	Deen			ectablish	ed as a co	it values are reflected for codes not payable by incoding, prease note mai mess variances applied as a courtesy to the general public and are not used for Medicare payment.	ne, prease note at used for Me	dicare payme	ntes nave on	3	
- 10	The but	deet neus	stablished as a courtesy to the general public and are not used for incurract. The highest neutrality reduction from the chiropractic demonstration is not	lemonstration	is not refle	cted in the R	reflected in the RVUs for CPT			3 The bu	dget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	temonstration	is not reflecte	d in the RV	Js for CPT	
J	odes 98	3940, 985	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	the files use	d for			codes 98	940,989	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	a will only be r	reflected in th	e files used	j,	
	Medican	Medicare payment.	at.	,						Medicar	Medicare payment	Addicare payment.	o mipumos o				
	Global	totals to	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.		•				Olicia	UDIGES IV	maintaine is 100 may use built and is	O I Communing.				

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Mal- Practice	RVUs ^{2,2,4}	0.03	0.00	0.03	0.02	00'0	0.02	0.00	0.00	00'0	0.02	0.00	0.01	0.02	0.00	0.01	0.02	0.00	0.02	0.03	00.00	0.03	0.04	0.00	0.04	0.05	0.00	0.04	0.05	0.00	0.05	0.04	0.00	0.04	0.05	00.00	0.05	0.04	0.00	0.04	0.05	0.00	0.05	ghts	
Facility PE	RVUs	ž:	Y.	0.54	Z Z	N.	0.32	Ν	ΥZ	0.09	NA	NA	0.30	Ϋ́	NA	0.32	NA	N A	0.34	NA	ΝA	0.18	NA	ΥN	0.17	ΥN	Ν	0.17	Y.	ΝA	0.25	Z V	ΥZ	81.0	Ϋ́	ΥZ	0.23	N A	ΝA	0.18	ΝΑ	NA	0.23	ition. All Rig	
Non- Facility PE	RVUs ^{2,3}	1.46	0.93	0.54	1.70	1.38	0.32	0.21	0.12	60.0	1.40	1.10	0.30	1.54	1.23	0.32	1.42	1.08	0.34	2.48	2.30	0.18	1.63	1,47	0.17	1.89	1.73	0.17	2.73	2.47	0.25	5.09	1.91	81.0	2.58	2.35	0.23	2.10	1.92	0.18	3.04	2.81	0.23	lical Associa	
Physi- clan Work	RVUS	0.94	0.00	0.94	99.0	0.00	99.0	0.17	0.00	0.17	0.54	00.0	0.54	0.54	0.00	0.54	0.57	0.00	0.57	95'0	0.00	0.56	0.55	00'0	0.55	0.54	0.00	0.54	0.81	0.00	0.81	0.59	0.00	0.59	0.74	0.00	0.74	0.58	00.0	0.58	0.76	0.00	0.76	merican Mec	
	Description	Opbth us, b w/non-quant a	Ophth us, b w/non-quant a	Ophth us, b w/non-quant a	Echo exam of eye, water bath	Echo exam of eye, water bath	Echo exam of eye, water bath	Echo exam of eye, thickness	Echo exam of eye, thickness	Echo exam of eye, thickness	Echo exam of eye	Echo exam of eye	Echo exam of eye	Echo exam of eye	Echo exam of eye	Echo exam of eye	Us exam of head and neck	Us exam of head and neck	Us exam of head and neck	Us exam, chest	Us exam, chest	Us exam, chest	Us exam, breast(s)	Us exam, breast(s)	Us exam, breast(s)	Us exam, abdom, complete	Us exam, abdom, complete	Us exam, abdom, complete	Echo exam of abdomen	Echo exam of abdomen	Echo exam of abdomen	Us exam abdo back wall, comp	Us exam abdo back wall, comp	Us exam abdo back wall, comp	Us exam abdo back wall, lim	Us exam abdo back wall, lim	Us exam abdo back wall, lim	Us exam k transpl w/doppler	Us exam k transpl w/doppler	Us exam k transpl w/doppler	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights				
	Status	Κ.	٧	4	¥.	٧	K	٧	٧	٧	4	4	¥	Y	Ą	¥	٧	¥	٧	٧	٧	Ą	٧	¥	Ą	4	٧	¥	4	4	X	¥	٧	4	¥	٧	K	Y	¥	٧	A	٧	V.	des and	Fi
	₽o₩		JC.	56		10	56		C	26		JC	56		TC	56		TC	56		IC	56		IC	56		TC	56		TC	56		TC	26		C	56		C	56		TC	56	CPT of	Reserved
(cp.La)	HCPCS	76512	76512	76512	76513	76513	76513	76514	76514	76514	76516	76516	76516	76519	76519	61592	76529	76529	76529	76536	76536	76536	76604	76604	76604	76645	76645	76645	76700	26700	76700	76705	76705	76705	76770	76770	0/19/	76775	76775	76775	9/19/	76776	76776		
. 8	Global																																								XXX	XXX	XXX		
Mal- Practice	RVUs2	0.0	0.0	0.0	0.0	0.00	0.02	0.00	0.00	000	0.01	0.00	0.01	0.0	0.00	0.05	0.0	000	0.06	0.07	0.00	0.07	0.00	0.00	0.00	0.00	0.00	0.0	0.00	0.00	0.00	0.00	000	0.00	0.03	0.00	0.03	0.05	0.00	0.04	0.03	0.00	0.02	ights	
Facility	RVU ₈ 23	K Z	Z.	0.13	Ϋ́	Ϋ́	0.09	0.00	X X	ΥZ	N.	N.A	90.0	N.	NA V	0.25	N.A	ΥZ.	0.31	NA	ΑN	0.51	NA	NA	0.00	AN	N A	00.0	N.	NA	0.00	٧X	Y Z	0.00	NA	ΥZ	0.21	ΥN	ď	0.92	ΝA	NA	0.52	ation. All R	
Non- Facility	Œ	1.52	1.39	0.13	NA	Ϋ́	0.09	0.00	0.56	ΥZ	1.25	1.19	90:0	1.22	0.97	0.25	2.78	2.47	0.31	6.42	5.91	0.51	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.53	2.32	0.21	2.82	1.90	0.92	1,66	1.14	0.52	edical Associ	
Physi- cian Work	RVUs.	0.38	0.00	0.38	0.00	00.0	0.27	0.00	0.00	0.00	0.20	0.00	0.20	0.79	0.00	0.79	0.98	00:0	86.0	1.40	0.00	1.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.63	0.00	0.63	1.55	00.0	1.55	0.94	0.00	0.94	American M	
	Description	Cine/video x-rays	Cine/video x-rays	Cine/video x-rays	Cine/video x-rays add-on	Cine/video x-rays add-on	Cine/video x-rays add-on	X-ray consultation	X-ray exam, dry process	Special x-ray contrast study	3d render w/o postprocess	3d render w/o postprocess	3d render w/o postprocess	3d rendering w/postprocess	3d rendering w/postprocess	3d rendering w/postprocess	CAT scan follow-up study	CAT scan follow-up study	CAT scan follow-up study	Mr spectroscopy	Mr spectroscopy	Mr spectroscopy	Fluoroscopic procedure	Fluoroscopic procedure	Fluoroscopic procedure	Ct procedure	Ct procedure	Ct procedure	Mri procedure	Mri procedure	Mri procedure	Radiographic procedure	Radiographic procedure	Radiographic procedure	Echo exam of head	Echo exam of head	Echo exam of head	Ophth us, b & quant a	Ophth us, b & quant a	Ophth us, b & quant a	Ophth us, quant a only	Ophth us, quant a only	Opbth us, quant a only	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	
	Status	∢	٧	∢	ပ	၁	Ą	_	٧	Ç	Ą	4	٧	Ą	٧	¥	Ą	Ą	4	z	Z	z	C	ပ	၁	ပ	၁	၁	ပ	၁	Ú	ပ	ပ	ပ	¥	4	Ą	4	٧	4	٧	٧	¥	des and c	
	Mod		JC	26		7C	56					7C	26		17	26		7C	56		ŢĊ	26		TC	56		2	56		TC	76		7	56		TC	56		TC.	56		IC	26	CPT co.	Reserved
, CPT ⁽²⁾	HCPCS	76120	76120	76120	76125	76125	76125	76140	76150	76350	76376	76376	76376	76377	76377	76377	76380	76380	76380	76390	76390	76390	76496	76496	76496	76497	76497	76497	76498	76498	76498	76499	76499	76499	76506	76506	76506	76510	76510	76510	76511	76511	76511	-	uz

Reserved.

Furthers are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

Reserved,

The lates are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT co²The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT Medicare payment.

*Global rotals for malpractice R VUs may not sum due to rounding.

Ţ				cla.	Facility	Facility	Na.		17				clan	Facility	Facility	-le M	
HCPCS	Mod	Statue	Description	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2.3}	RVUs.3.4	Global	HCPCS	Po W	Status	Description	RVU8 ^{2,3}	RVUs ^{2,3}	RVUs23	RVUs 23.4	Global
26800		¥	Us exam, spinal canal	1.13	2.42	NA	90.0	XXX	76820		٧	Umbilical artery echo	0.50	0.56	۲	20.0	XXX
26800	77	¥	Us exam, spinal canal	0.00	2.01	NA	0.00	xxx	76820	rc	Ą	Umbilical artery echo	0.00	0.38	NA	0.00	XXX
26800	56	٧	Us exam, spinal canal	1.13	0.41	0.41	90:0	XXX	76820	56	K	Umbilical artery echo	0.50	61.0	0.19	0.02	XXX
10891		4	Ob us < 14 wks, single fetus	66.0	2.24	ΝA	0.05	XXX	76821		Ą	Middle cerebral artery echo	0.70	1.73	۲ Z	0.03	XX
10891	IC	٧	Ob us < 14 wks, single fetus	0.00	1.91	NA	0.00	XXX	76821	TC	Ą	Middle cerebral artery echo	0.00	1,47	۲ Z	0.00	XX
10891	26	∢	Ob us < 14 wks, single fetus	0.99	0.33	0.33	0.05	XXX	76821	56	٧	Middle cerebral artery echo	0.70	0.26	0.26	0.03	xxx
76802		∢	Ob us < 14 wks, addÆl fetus	0.83	0.93	0.93	0.04	ZZZ	76825		Ą	Echo exam of fetal heart	1.67	4.00	Z Z	80.0	XXX
76802	IC	∢	Ob us < 14 wks, addÆl fetus	00.0	0.64	0.64	0.00	777	76825	5	٧	Echo exam of fetal heart	0.00	3,40	NA NA	0.00	XXX
76802	56	٧	Ob us < 14 wks, addÆ1 fetus	0.83	0.29	0.29	0.04	222	76825	56	4	Echo exam of fetal heart	1.67	19'0	0,61	0.07	XXX
76805		∢	Ob us >/= 14 wks, sngl fetus	66'0	2.78	Ν	0.05	XXX	76826		Ą	Echo exam of fetal heart	0.83	2.52	ΝΑ	50.0	XXX
76805	TC	¥	Ob us >/= 14 wks, sngl fetus	00'0	2.43	Ν	00'0	XXX	76826	TC	٧	Echo exam of fetal heart	000	2.24	ΝΆ	0.00	XXX
76805	26	٧	Ob us >/= 14 wks, sngl fetus	66.0	0.34	0.34	0.05	XXX	76826	56	¥	Echo exam of fetal heart	0.83	0.30	0.30	0.04	XXX
76810		٧	Ob us >/= 14 wks, add! fetus	0.98	1.55	1.55	0.05	222	76827		¥	Echo exam of fetal heart	0.58	1.01	NA	0.03	XXX
76810	TC	4	Ob us >/= 14 wks, addl fetus	0.00	1.21	1.21	0.00	777	76827	C	¥	Echo exam of fetal heart	0.00	08'0	K Z	0.00	XXX
76810	56	<	Ob us >/= 14 wks, addl fetus	86'0	0.34	0.34	0.04	222	76827	56	٨	Echo exam of fetal heart	0.58	0.21	0.21	0.03	XXX
11897		٧	Ob us, detailed, sngl ferus	1.90	2.54	Ν	60'0	XXX	76828		۷	Echo exam of fetal heart	0.56	0.63	NA	0.03	XXX
76811	J.	<	Ob us, detailed, snel fetus	000	2.22	NA	0.01	XXX	76828	IC	4	Echo exam of fetal heart	0.00	0.42	Y.	0.00	XXX
11897	26	٧	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.08	XXX	76828	26	Ą	Echo exam of fetal heart	0.56	0.21	0.21	0.03	XXX
76812		4	Ob us detailed addl fetus	1.78	3.72	3.72	0.08	77.7	76830		4	Fransyapinal us non-oh	690	2.48	A.Z.	0.04	XXX
76812	JL	. ⊲	Ob us, detailed addl fens	000	3.05	3.05	100	222	76830	J.C		Fransvaeinal us non-oh	000	2.76	AN	0.00	XXX
76817	3,0	: ∢	Oh us detailed addl fetus	1.78	0.67	290	800	222	01897	36	. ∢	Fransvaginal us. non-oh	0.69	0.23	0.23	0.04	XXX
76913	2	; <	Ohne michal mane 1 aget	81.	200	Y.	900	XXX	76831	ì	. 4	Coho even meens	62.0	2 50	N A		XXX
21697	J.L	< -	Oh us michal mass 1 gost	000	62.	(e	000	XXX	16897	J.C	.	Coho even menus	7/:0	2.73	. z	000	X X X
21007	2 2	ς -	Ot us intend meas, 1 gest	0.00	6.0	777	90.0	X	1690/	2 %	۲ -	cond exam, ureins	00.0	52.7	2,00	900	< >>
7,081.5	97	∢ .	On us nuchal meas, 1 gest	1.18	‡ .	0,44	0.00	777	10831	97	ξ.	Ecno exam, uterus	0.72	0.27	0.27	0.03	X
76814		٧	Ob us nuchal meas, add-on	66.0	1.15	ď.	0.05	XXX	76856		ď	Us exam, pelvic, complete	0.69	2.46	K Z	0.04	XXX
76814	TC.	<	Ob us nuchal meas, add-on	000	0.77	V.	0.00	XXX	76856	<u>ر</u>	¥	Us exam, pelvic, complete	0.00	2.24	V.	0.00	XX
76814	56	∢:	Ob us nuchal meas, add-on	66'0	0.38	0.38	0.0 4	XXX	16856	56	٧	Us exam, pelvic, complete	69.0	0.22	0.22	0.04	XX
76815		٧	Ob us, limited, fetus(s)	0.65	1.65	ΝA	0.03	XXX	76857		<	Us exam, pelvic, limited	0.38	2.02	Y Z	0.03	XXX
76815	TC	Ą	Ob us, limited, fetus(s)	0.00	1.43	Ν	0.00	XXX	76857	JC	¥	Us exam, pelvic, limited	0.00	1.90	NA	0.00	XX
76815	56	¥	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.03	XXX	76857	56	٧	Us exam, pelvic, limited	0.38	0.12	0.12	0.03	XX
76816		Y	Ob us, follow-up, per fetus	0.85	2.20	Ϋ́	0.04	XXX	02897		V	∃s exam, scrotum	0.64	2.46	Z Z	0.05	XXX
76816	C	¥	Ob us, follow-up, per fetus	0.00	1.89	NA	0.00	XXX	76870	TC	<	Us exam, scrotum	0.00	2.27	NA	0.00	XXX
76816	56	K	Ob us, follow-up, per fetus	0.85	0.31	0.31	0.04	XXX	76870	56	∢	Us exam, scrotum	0.64	0.20	0.20	0.04	XX
76817		Ą	Transvagina! us, obstetric	0.75	1.84	NA	0.04	XXX	76872		٧	Us, transrectal	69.0	2.64	A'N	0.05	XXX
76817	TC	4	Transvaginal us, obstetric	0.00	1.59	NA	0.00	XXX	76872	TC	V	Us, transrectal	0.00	2.42	NA V	0.00	XX
76817	56	4	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	XXX	76872	56	Κ.	Us, transrectal	69.0	0.23	0.23	50:0	XX
76818		¥	Fetal biophys profile w/nst	1.05	5.09	NA	0.05	XXX	76873		₹	Echograp trans r, pros study	1.55	2.94	NA A	0.10	XXX
76818	7	4	Fetal biophys profile w/nst	0.00	1.70	NA	0.00	XXX	76873	IC	V	Echograp trans r, pros study	00.00	2.39	ΝΑ	0.00	XX
76818	76	¥	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	XXX	76873	56	٧	Echograp trans r, pros study	1.55	0.55	0.55	0.10	XXX
61892		Ą	Fetal biophys profil w/o nst	0.77	1.51	NA	0.04	XXX	76880		₹	Js exam, extremity	0.59	3.04	AA	0.03	XXX
61892	TC	4	Fetal biophys profil w/o ust	0.00	1.24	ΥN	0.00	XXX	76880	JC	¥	Us exam, extremity	0.00	2.86	Z Z	0.00	XXX
61892	76	¥	Fetal biophys profil w/o nst	0.77	0.27	0.27	0.03	XXX	76880	56	<	Us exam, extremity	0.59	0.18	0.18	0.03	XXX
	CPT	codes and	CPT codes and descriptions only are convright 2009 American Medical Association. All Rights	merican Med	ical Associa	tion. All Ris	phts			CPT co	les and de	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	perican Medi	cal Associati	on. All Righ	22	
	Reserved	ed.								Reserved					2		
	2 If val	lues are re	² If values are reflected for codes not payable by Medicare, please note that these values have been	re, please not	e that these	values have	peen			2 If value	are refle	If values are reflected for codes not payable by Medicare, please note that these values have been	re, please not	e that these vi	alues have be	en	
	establi	shed as a (established as a courtesy to the general public and are not used for Medicare	t used for Me	dicare payment	ent.	4			establishe	d as a con	established as a courtesy to the general public and are not used for Medicare payment.	t used for Me	dicare payme	ig.		
	The	ondget ner	The budget neutrality reduction from the chiropractic demonstration is not reflected in the K VUs	emonstration	is not reflec	ted in the K	reflected to the K VUS for UP I			ong ant .	get neutra	The budget neutrally reduction from the chiropractic demonstration is not reflected in the RVUs for CP1 and 08040, and 08041, and 08042. The seminad reduction will call, by an addition to the filter used for	emonstration	is not reflect	ed in the KV	S for CP1	
	Medica	Medicare navment	2741, and 26742. The required reduction	will bank be	or concern in	TACE CALLY AND	3			Medican	Medican: navment	is and 2072: A de respunda reducinos	are card on	circula in the	naen emir o	5	
	Glob	al totals fo	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.						Global t	otals for r	Global totals for malpractice RVUs may not sum due to rounding.	rounding.				
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	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	222	222	222	XXX	XXX	XX	X	XXX	XXX	X X	X X X	XX	XXX	XXX	XXX	XXX	XXX	X X	XX	XXX	XXX	XXX	XXX	XXX	XXX			ŧ	÷	
Mal- Practice	0.05	0.00	0.05	0.0	0.00	0.07	0.00	0.00	0.0	0.00	00.0	0.19	00'0	0.00	0.00	0.03	0.00	0.03	0.04	0.00	0.04	0.04	0.00	40.0	90.0	3 6	80.0	00.0	0.07	00:0	0.00	0.29	000	0.05	0.14	0.00	0.13	00.0	00.0	0.31	shits	e peeu		EVUS for CF ed for	
Facility PE PV/1623	S V	N.	0.15	VZ:	AN S	0.52	Z.	Ϋ́	0.02	Y Y	NA	0.40	Ν¥	NA	0.00	NA	NA	0.12	NA	Y.	0.21	Y :	Y S	0.23	K V	244	Y Y	ž	0.35	ΝA	YZ.	1.19	Z 2	0.32	Z	Ϋ́	0.47	NA	NA	1.29	ation, All R	values have	ment.	cted in the later the later	
Non- Facility PE	2.26	2.11	0.15	V.	Y S	0.32	0.12	0.10	0.02	NA	NA	0.40	0.00	0.00	0.00	2.62	2.50	0.12	1.38	1.18	0.21	<u>.</u> 2	0.81	0.23	16.85	10.4	55	1.20	0.35	ΝĀ	₹ :	1.19	7,00	0.73	525	4.79	0.47	NA	N.	1.29	dical Associ	ote that these	ledicare pay	n is not refle reflected in	
Physi- cian Work	0.40	0.00	0.40	0.00	0.00	0.81	0.05	0.00	0.05	0.00	0.00	1.20	0.00	0.00	0.00	0.38	0.00	0.38	0.54	0.00	0.54	0.60	0.00	0.60	17.1	3 :	1.16	0.00	1.16	0.00	0.00	3.99	0.83	0.85	1 50	0.00	1.50	0.00	0.00	4.24	merican Me	ire. please oc	ot used for N	lemonstratio 1 will only be	o rounding.
One market state of	Ultrasound exam follow-up	Ultrasound exam follow-up	Ultrasound exam follow-up	Gl endoscopic ultrasound	Gl endoscopic ultrasound	Gi endoscopic ultrasound	Us bone density measure	Us bone density measure	Us bone density measure	Us guide, intraop	Us guide, intraop	Us guide, intraop	Echo examination procedure	Echo examination procedure	Echo examination procedure	Fluoroguide for vein device	Fluoroguide for vein device	Fluoroguide for vein device	Needle localization by xray	Needle localization by xray	Needle localization by xray	Fluoroguide for spine inject	Fluoroguide for spine inject	Fluoroguide for spine inject	Ct scan for localization	Ct scan for rocalization	Ct scan for needle bionsy	Ct scan for needle biopsy	Ct scan for needle biopsy	Ct guide for tissue abfation	Ct guide for tissue ablation	Ct guide for tissue ablation	Ct scan for therapy guide	Ct scan for therapy guide	Mr onidance for needle place	Mr guidance for needle place	Mr guidance for needle place	Mri for tissue ablation	Mri for tissue ablation	Mri for tissue ablation	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	keserved. If values are reflected for codes not pavable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dedicare payment. Global totals for malpractice RVUs may not sum due to rounding.
į	Status A	₹	<	ان	ပ .	∢ .	<	V	۷	ပ	O	¥	Ç	Ų	ပ	٧	¥	٧	4	¥	4	₹ .	Α.	∢ .	< →	ζ -	< <	: ∢	٧	J	O ·	۷.	< <	< <	: ∢	: ∢	¥	U	ပ	4	codes and	ed. ues are ref	shed as a c	ndget neul 98940, 989	Medicare payment. Global totals for r
3		IC	56		TC :	56		TC	56		IC	56		TC	56		TC	56		TC	56	I	IC.	70	Ę	אַ נַ	77	TC	56		2	56	Ę	ر د د	:	TC	56		TC	56	CPT	Reserved 2 If values	establi	codes	Medica 4 Globs
CPT ^{1,3}	76970	02692	02692	76975	76975	76975	76977	76977	76977	26694	26694	26698	16999	76999	66691	1001	17001	17001	77002	77002	77002	77003	77003	77003	110//	17011	77012	77012	77012	77013	77013	77013	77014	77014	77021	77021	77021	77022	77022	77022					
Mat- Practice	0.05 XXX																												0.03 XXX					XXX 000		XXX 0000				0'00 XXX	ights	heen		VUs for CPT d for	
Facility PE	NA NA	NA	0.23	Y.	¥.	0.25	X Y	NA	0.22	NA	NA	0.23	NA	NA	0.62	0.58	0.49	60.0	NA	Y.	0.67	AN	V.	0.51	V ;	K Z	7.0 V	X	0.26	NA V	Y.	0.14	Y X	N 0	V V	ž	0.22	ΥN	NA	0.47	tion. All R	values have	nent.	t reflected in the RVUs ted in the files used for	
Non- Facility PE	2.97	2.73	0.23	2.59	2.34	0.25	1.43	1.21	0.22	NA	N.	0.23	5.46	4.85	0.62	0.58	0.49	0.09	NA	NA	19'0	Y.	Ϋ́	0.51	5.5	50.4	N.A	N N	0.26	4.0	0.30	0.14	0.53	6.0	1 13	0.89	0.22	1.02	0.56	0.47	lical Associa	te that these	edicare pay	n is not refle reflected in	
Physi- clan Work	0.74	00:00	0.74	0.62	0.00	0.62	0.67	0.00	19.0	00.0	00:0	0.67	661	00'0	1.99	0.30	00.0	0.30	00.0	0.00	2.00	0.00	0.00	1.34	79.0	0.00	/9/0	0.00	0.67	0.38	0.00	0.38	0.38	0.00	250	00.0	0.58	1.34	00.0	1.34	American Mex	icare, please no	not used for M	c demonstration ion will only be	e to rounding.
ć	Us exam infant hips, dynamic	Us exam infant hips, dynamic	Us exam infant hips, dynamic	Us exam infant hips, static	Us exam infant hips, static	Us exam infant hips, static	Echo guide, cardiocentesis	Echo guide, cardiocentesis	Echo guide, cardiocentesis	Echo guide for heart biopsy	Echo guide for heart biopsy	Echo guide for heart biopsy	Echo guide for artery repair	Echo guide for artery repair	Echo guide for artery repair	Us guide, vascular access	Us guide, vascular access	Us guide, vascular access	Us guide, tissue ablation	Us guide, tissue ablation	Us guide, tissue ablation	Echo guide for transfusion	Echo guide for transfusion	Echo guide for transfusion	Echo guide for biopsy	Echo guide for biopsy	Echo mide tof blopsy Echo mide villus campling	Echo guide, villus sampling	Echo guide, villus sampling	Echo guide for amniocentesis	Echo guide for amniocentesis	Echo guide for amniocentesis	Echo guide, ova aspiration	Echo guide, ova aspiration	Echo midanca radiotheran	Echo guidance radiotherapy	Echo guidance radiotherapy	Echo guidance radiotherapy	Echo guidance radiotherapy	Echo guidance radiotherapy	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. ? If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dedicare payment. Global totals for matpractice RVUs may not sum due to rounding
ě	Status	¥	¥	¥	∢	V	4	٧	∢	ပ	U	∢	۷	A	¥	٧	¥	٧	ပ	ပ	*	Ö	ပ	٧	∢ .	∢ •	e (Ç	A	4	∢	∢ .	∢ .	< <	(<	< ∢	. Α	٧	٧	٧	odes and	ed.	thed as a c	udget neu 8940, 989	Medicare payment. 4 Global totals for n
	0	2	56		2	56		2	56		77	56		Ω	56		15	56		2	56		2	56	6	<u>ر</u> ي	97	C	56		7C	56	(ץ ב	2	C	76		1C	56	CPT c	Reserved.	stablis	The b	ledica Globa
CPT ⁽⁻³)																																										HE (1	ű.	. 5	Σ.,

	Global	3	\{	XXX	××	XX	XXX	XXX		3	XX	XXX	XXX	XXX	2	XXX	XXX	XXX	XXX	XXX	\$ 2	XX	X	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		ΥΥΥ Υ	XXX	XX	XX	ž	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	*								
Mai- Practice	RVUs.	0.03	9.04	0.00	0.0	0.05	0.00	0.05	000	† 500	0.00	0.04	0.02	000	00.0	0.02	0.01	0.00	0.01	100	0.01	0.00	0.01	10.0	0.00	0.01	10.0	000	0.01	10:0	000	8 6		0.12	90.0	0.11	0.08	0.13	0.20	0.04	0.00	0.04	0.07	0.00	90.0	010	000	0.00	ghts		peen		VUs for CPT	l for		
Facility PE	RVUs.	0.14 4 4	K.	ΥZ	0.17	ΑN	N.	0.21	1 1 1	ζ:	ΥX	0.12	NA	× 2	Y	0.08	Y Z	Ϋ́	0.08	4Z	ξ;	Z Z	0.07	NA	Ϋ́Z	0.08	A	X	90'0	Y.	ΥN	0.03	0.0	ď;	Υ.	0.50	0.56	0.80	617	ΝA	Ϋ́	0.27	NA	ΥZ	0.40	ĄZ	V V	Z.	ion, All Rig		values bave	ent.	ted in the R'	he files usec		
Non- Facility PE	RVUs ^{2,3}	t (70.7	1.85	0.17	1.90	1.69	0.31	1 6	0.70	0.58	0.12	2.59	15.0	10.2	0.08	0.80	0.71	0.08	2	5.7	0.97	0.02	0.47	0.39	0.08	0.52	0.45	90'0	0.41	0.33	50.0	0.0	8.21	7.70	0.50	0.56	0.80	1.19	3,96	3.69	0.27	7.16	6.77	0.40	11 94	11.35	6.11	lical Associat		te that these	edicare paym	is not reflec	reflected in t		
Physi- cian Work	RVUs ^{2,3}	0.45	0.54	0.00	0.54	0.70	0.00	02.0	2.0	0.31	0.00	0.31	0.25	000	9.0	0.25	0.22	0.00	0.22	0,0	07.0	0.00	0.20	0.22	0.00	0.22	0.17	000	0.17	0.20	000	0.00	07.0	09:1	0.00	1.60	1.39	2.11	3.14	0.70	00'0	0.70	1.05	0.00	1.05	45	00.1	0.00	merican Mec		ue, please no	ot used for M	lemonstration	will only be	;	o rounding.
	Description	X-rays, bone survey, limited	X-rays, bone survey complete	X-rays, bone survey complete	X-rays, bone survey complete	X-rays, bone survey, infant	X-rays, hone survey, infant	V may home common infant	A-lays, bone survey, miant	Joint survey, single view	Joint survey, single view	Joint survey, single view	Cr hone density axial	Or home density, axial	Ct bone density, axial	Ct bone density, axial	Ct bone density, peripheral	Ct bone density, peripheral	Ct hone density, peripheral	Due hone demoits axial	DAS DOUG UCININ, AMISI	Dxa bone density, axial	Dxa bone density, axial	Dxa bone density/peripheral	Dxa bone density/peripheral	Dxa bone density/nerinheral	Dya hone density year fy	Dya bone density yerr fx	Dxa hone density, vert fx	Radiographic absorptionetry	Padiographic absorptionatry	Podiographic absorptioned y	Kaulographic absorptionicus	Magnetic image, bone marrow	Magnetic image, bone marrow	Magnetic image, bone marrow	Radiation therapy planning	Radiation therapy planning	Radiation therapy planning	Set radiation therapy field	Set radiation therapy field	Set radiation therapy field	Set radiation therapy field	Set radiation therapy field	Set radiation therapy field	Cot rediction therany field	Set faulation therapy field	set radiation incrapy tiero	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	±	Global totals for malpractice RVUs may not sum due to rounding.
	Status	∢ •	ď	¥.	Y	∢	. ∢		٠ ٠	4	٧	¥	. ∢	. <	ζ.	4	Y	¥	٧		< ⋅	٧	V	V	٧	4	. 4	٠ ۲	. 4	. ∢	: •	< -	٠.	¥	٧	¥	٧	4	Y	¥	¥	٧	∢.	٧	٧	<	< <	₹	codes and o	ed.	ues are refl	shed as a co	ndget neut	8940, 989	Medicare payment	I totals for
	Mod	56		Ω	76		J	, ,	07		7	56		Ę	: ۲	56		2	36	2		C	56		TC	36	1	T	26	2	T	2 2	07		υ	26					TC	56		TC	56		Ţ	ر.	CPT	Reserved.	2 If value	establis	3 The b	codes 5	Medica	*Globe
CPT'3/	HCPCS	77074	77075	77075	77075	77076	77077	35055	0/0//	11011	77077	77077	77077	27070	1018	77078	77079	77079	97077	77090	/ / 080	77080	77080	77081	77081	77081	77087	77082	77082	77083	77083	77063	11003	77084	77084	77084	77261	77262	77263	77280	77280	77280	77285	77285	77285	22300	067//	06777								
fal- critos	-					XXX 00																														.12 XXX					XXX 00						, .	•					for CPT			
ity Mal-	RVUs23.4	0.14	0.00	0.14	0.04	0.00	0.04	500	0.00	00.0	00:0	000	000	00.0	000	0.03	000	0.02	003	000	000	0.03	0.05	000	0.05	0.07	000	900	0.05	0.0	90'0	0,0	0.12	0.00	0.11	0.12	0.00	0.11	90:0	0.02	000	10.0	0.04	000	0.04	600	0.00	0.00	All Rights		have been		the RVUs for CPT	s used for		
Facility	RVUs23 RVUs234	NA 0.14	NA 0.00	0.50 0.14	NA 0.04	000 AN	0 0 71 0 004	1000	0.18	0.16 0.00	0.02 0.00	0.18 0.00	0.16	00:0	0.02 0.00	NA 0.03	NA 0.00	0.11 0.02	NA 003	600	NA 0.00	0.14 0.03	NA 0.05	000 AN	0.21 0.05	NA 0.07	000 VN	000	5000 AN	000 VN	333 000	0.02	NA 0.12	NA 0.00	0.50 0.11	NA 0.12	NA 0.00	0.50 0.11	0.87 0.06	NA 0.02	0.00 VA	0.06	NA 0.04	000 VX	0.11 0.04	2000	NA 0.03	0.00	ociation, All Rights		ese values have been	payment.	effected in the RVUs for CPT	d in the files used for		
	RVUs23 RVUs234	0.14	NA 0.00	0.50 0.14	NA 0.04	000 AN	0 0 71 0 004	1000	18 0.00	16 0.16 0.00	00:0	0.18 0.00	0.16	00:0	0.02 0.00	NA 0.03	NA 0.00	0.11 0.02	003	600	NA 0.00	0.14 0.03	NA 0.05	000 AN	0.05	70 0 NA 0007	000 VN	000	5000 AN	000 VN	333 000	0.02	NA 0.12	NA 0.00	0.50 0.11	0.12	NA 0.00	0.50 0.11	0.87 0.06	NA 0.02	32 NA 0.00	000 900 900	70 NA 0.04	000 VX	11 0.11 0.04	2000	0.00	0.00	ledical Association, All Rights		note that these values have been	Medicare payment.	ion is not reflected in the RVUs for CPT	be reflected in the files used for		
Facility	RVUs23 RVUs23 RVUs234 C	1.72 NA 0.14	1.22 NA 0.00	0.50 0.14	NA 0.04	0.57 NA 0.00	007 017 004	1000	0.18 0.18	0.16 0.16 0.00	02 0.02 0.00	0.18 0.18 0.00	0.16 0.16 0.00	000 010 000	0.02 0.02 0.00	1.09 NA 0.03	NA 0.00	0.11 0.11 0.02	1.48 NA 0.03	2000	1.35 NA 0.00	0.14 0.14 0.03	1.45 NA 0.05	1.24 NA 0.00	0.21 0.21 0.05	70 0 NA 0007	000 VN 691	2000 200 2000	500 W 801	1 07 AM 000	333 000	0.22 0.22	NA 0.12	11.45 NA 0.00	0.50 0.50 0.11	NA 0.12	11.33 NA 0.00	50 0.50 0.11	87 0.87 0.06	38 NA 0.02	0.32 NA 0.00	0.06 0.06	0.70 NA 0.04	0.58 NA 0.00	0.11 0.11 0.04	200	1.27 NA 0.03	0.00	American Medical Association, All Rights		are, please note that these values have been	or used for Medicare payment.	demonstration is not reflected in the RVUs for CPT	n will only be reflected in the files used for		to rounding.
Non- Facility Facility PE PE	Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,4} C	1.59 1.72 NA 0.14	0.00 1.22 NA 0.00	1.59 0.50 0.50 0.14	Guidance for needle, breast 0.56 0.74 NA 0.04	Guidance for needle breast 0.00 0.57 NA 0.00	Cuidamos for mondly banned 0.56 0.17 0.17 0.04	Culturative to accurate the control of the control	Computer dx mammogram add-on 0.00 0.18 0.18 0.00	0.00 0.16 0.16 0.00	Computer dx mammogram add-on 0.06 0.02 0.02 0.00	Comp screen mammooram add-on 0.06 0.18 0.18 0.00	Comparison manuscram add on 0.00 At 0.16 0.00	Comp Scient manninggram auc-on	Comp screen mammogram add-on 0.06 0.02 0.02 0.00	1.09 NA 0.03	X-ray of mammary duct 0.00 0.98 NA 0.00	0.36 0.11 0.11 0.02	V min of manimum diote 0.45 1.48 NA 0.03	A-idy of the manning y ducts	X-ray of mammary ducts 0.00 1.35 NA 0.00	X-ray of mammary ducts 0.45 0.14 0.14 0.03	Mammogram, one breast 0.70 1.45 NA 0.05	0.00 1.24 NA 0.00	Mammooram one breest 0.70 0.21 0.05	Manuscratic back beneath 0.07 1.90 NA 0.07	Manufacture Leaf Leaves 000 162 NA 000	2000 200 2000	Manufacture consequence 0.10 1.20 NA 0.05	Manualgram, screening 0.10 1.20 1.70 0.00	Manmoham, serconning	Mammogram, screening 0.70 0.22 0.03	Mri, one breast 1.63 11.93 NA 0.12	11.45 NA 0.00	0.50 0.50 0.11	11.83 NA 0.12	Mri, both breasts 0.00 11.33 NA 0.00	0.50 0.50 0.11	0.87 0.87 0.06	0.19 0.38 NA 0.02	X-rays for hone age 0.00 0.32 NA 0.00	X-rays for hone age 0.19 0.06 0.06 0.01	X-rays, hone length studies 0.27 0.70 NA 0.04	X-rays hone length studies 0.00 0.58 NA 0.00	X-rays, hone length studies 0.27 0.11 0.11 0.04	the state of the s	X-rays, bone survey, limited 0.45 1.27 NA 0.03	0.00	es and descriptions only are copyright 2009 American Medical Association. All Rights		are reflected for codes not navable by Medicare, please note that these values have been	4 as a courteev to the general rublic and are not used for Medicare payment.	the second second from the chromactic demonstration is not reflected in the RVUs for CPT	40, 98941, and 98942. The required reduction will only be reflected in the files used for	payment.	stals for malpractice RVUs may not sum due to rounding.
Non- Facility Facility PE PE	RVUs23 RVUs23 RVUs23 RVUs234 C	A Stereotact guide for brst bx 1.59 1.72 NA 0.14	0.00 1.22 NA 0.00	A Stereotact guide for brst bx 1.59 0.50 0.50 0.14	Guidance for needle, breast 0.56 0.74 NA 0.04	A Guidance for needle breast 0.00 0.57 NA 0.00	Cuidamos for mondly banned 0.56 0.17 0.17 0.04	A Cumulic to necute, predat	A Computer dx mammogram add-on 0.00 0.18 0.18 0.00	A Computer dx mammogram add-on 0.00 0.16 0.16 0.00	A Computer dx mammogram add-on 0.06 0.02 0.02 0.00	A Compacted name of the control of t	A Court against the court of th	A Comp sciect manning an autority 0.00 0.10 0.10 0.00	Comp screen mammogram add-on 0.06 0.02 0.02 0.00	X-ray of mammary duct 0.36 1.09 NA 0.03	X-ray of mammary duct 0.00 0.98 NA 0.00	A X-ray of mammary duct 0.36 0.11 0.02	A V serior of manuscript diores 0.045 148 NA 0.03	A Ariay of mamman y ducts	X-ray of mammary ducts 0.00 1.35 NA 0.00	A X-ray of mammary ducts 0.45 0.14 0.14 0.03	Mammogram, one breast 0.70 1.45 NA 0.05	Mammooram one breast 0.00 1.24 NA 0.00	A Memoran one breast 0.70 0.21 0.05	A Manual Control of the Control of t	A Manuackani, out towasts correction and the correction of the cor	Manuscript Lock broads 0.90 0.30 1.00 1.00 0.00	A Manuscription conserving 0.20 0.20 0.20 0.20	A Mammogram, screening 0.10 1.20 17. NA 0.00	A Madmingfall, Seconds	Mammogram, screening 0.70 0.22 0.03	A Mri, one breast 1.65 11.95 NA 0.12	A Mri, one breast 0.00 11.45 NA 0.00	Mri, one breast 1.63 0.50 0.50 0.11	Mri, both breasts 1.63 11.83 NA 0.12	A Mri, both breasts 0.00 11.33 NA 0.00	Mri, both breasts 1.63 0.50 0.50 0.11	0.41 0.87 0.87 0.06	X-rays for hone age 0.19 0.38 NA 0.02	X-rays for hone age 0.00 0.32 NA 0.00	A X-rays for hone age 0.19 0.06 0.06 0.01	A X-rays, hone length studies 0.27 0.70 NA 0.04	X-rays hone length studies 0.00 0.58 NA 0.00	A X-rays, hone length studies 0.27 0.11 0.11 0.04	COV VIX COL TO COLOR MAN TO COLOR TO CO	A X-rays, bone survey, limited 0.45 1.27 NA 0.03	0.00	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved	are reflected for codes not navable by Medicare, please note that	setablished as a courteev to the general nublic and are not used for Medicare payment.	Security of the highest neutrality reduction from the chiromactic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	'Global totals for malpractice RVUs may not sum due to rounding.

	XXX	XXX	XXX	XXX	XXX	XX	XXX	XX	XX	XXX	XXX	XX	XX	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	XXX	XX	XXX	XXX	XXX	XXX	XX	XX	XXX	XXX	XX	XX	XX	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX	
Mai- Practice	0.05	80.0	0.00	0.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	00:0	00'0	0.00	0.00	00.0	0.02	0.00	0.02	0.00	0.00	0.23	0.11	0.50	0.81	0.13	10.0	0.13	0.00	0.00	0.00	ghts
Facility PE	6.32	N.	NA	0.47	NA	NA	N A	NA	Z V	Y.	ΝA	0.00	NA A	N.	NA	N.	NA	N.	NA	NA	NA	NA	NA	NA	NA	ΝA	NA	Ϋ́	NA	0.15	NA	NA	1.56	0.85	3.03	NA	NA	NA	0.79	ΑN	X	0.00	tion. All Ri
Non- Facility PE	RVUs	2.50	2.03	0.47	0.99	2.64	0.00	12.82	22.92	0.00	0.00	0.00	0.42	3.07	2.70	2.92	2.98	5.63	3.71	3.99	3.99	4.88	4.92	5.34	5.37	0.32	7.98	2.13	1.98	0.15	6.28	6.55	1.56	0.85	3.03	5,21	1.87	1.08	0.79	0.00	0.00	00'0	dical Associa
Physi- clan Work	0.84	1.24	0.00	1.24	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0,00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.39	0.00	0,39	0.00	0.00	3.70	1.8.1	7.92	13.00	2.09	0.00	2.09	0.00	000	0.00	vmerican Me
	Description Radiation treatment aid(s)	Radiation treatment aid(s)	Radiation treatment aid(s)	Radiation treatment aid(s)	Radiation physics consult	Radiation physics consult	Srs, multisource	Srs, linear based	Sbrt delivery	External radiation dosimetry	External radiation dosimetry	External radiation dosimetry	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiation treatment delivery	Radiology port film(s)	Radiation tx delivery, imrt	Stereoscopic x-ray guídance	Stereoscopic x-ray guidance	Stereoscopic x-ray guidance	Neutron beam tx, simple	Neutron beam tx, complex	Radiation tx management, x5	Radiation therapy management	Stereotactic radiation trmt	Sbrt management	Special radiation treatment	Special radiation treatment	Special radiation treatment	Radiation therapy management	Radiation therany management	Radiation therapy management	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights
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	Mod 26	ì	TC	56							TC	56																	10	56								Ω	56		2	36	CPT co
CPT ¹³	HCPCS 77333	77334	77334	77334	77336	77370	77371	77372	77373	77399	77399	77399	77401	77402	77403	77404	77406	77407	77408	77409	77411	77412	77413	77414	77416	77417	77418	77421	77421	77421	77422	77423	77427	77431	77432	77435	77470	77470	77470	77499	77499	77499	
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Mai- Practice	RVUs**** Global																									90:0		90.0	60.0									0.03 XXX		003	0.05	000	20
Mai- Practice	. RVUs ^{2.3.4}	0.29	0.01	0.27	0.00	0.00	0.00	0.04	0.00	0.04	0.50	0.02	0.48	0.04	0.00	0.04	0.07	0.00	90:0	0.10	0.00	60'0	90.0	00'0	90'0		0.00			0.00	90:0	0.13	10.0	0.13	0.05	0.00	0.05	0.03	0.00	0.03			All Rights
Facility Mai- PE Practice	RVUs*** RVUs**** 0.59 0.59	NA 0.29	NA 0.01	1.73 0.27	NA 0.00	NA 0.00	0.00 0.00	NA 0.04	NA 0.00	0.24 0.04	NA 0.50	NA 0.02	3.02 0.48	NA 0.04	NA 0.00	0.26 0.04	NA 0.07	NA 0.00	0.40 0.06	NA 0.10	NA 0.00	60.0	NA 0.06	NA 0.00	0.36 0.06	NA	NA 0.00	0.35	NA A	NA 0.00	0.53 0.08	NA 0.13	NA 0.01	0.79 0.13	NA 0.05	NA 0.00	0.33 0.05	NA 0.03	0.00 AN	021 003	¥ Z	, V	sociation. All Rights
Non- Facility Facility Mai- PE PE Practice	0.59 0.59 0.09	NA 0.29	NA 0.01	1.73 0.27	NA 0.00	NA 0.00	0.00 0.00	NA 0.04	NA 0.00	0.24 0.04	NA 0.50	NA 0.02	3.02 0.48	NA 0.04	NA 0.00	0.26 0.04	NA 0.07	NA 0.00	0.40 0.06	NA 0.10	NA 0.00	60.0	NA 0.06	NA 0.00	0.36 0.06	NA	NA 0.00	0.35	NA A	NA 0.00	0.53 0.08	NA 0.13	NA 0.01	0.79 0.13	NA 0.05	NA 0.00	0.33 0.05	NA 0.03	0.00 AN	021 003	¥ Z	, V	Aedical Association. All Rights
Facility Mai- PE Practice	0.59 0.59 0.09	6.92 NA 0.29	5.19 NA 0.01	1.73 0.27	0.00 NA 0.00	0.00 NA 0.00	0.00 0.00	1.09 NA 0.04	0.86 NA 0.00	0.24 0.24 0.04	51.05 NA 0.50	48.03 NA 0.02	3.02 3.02 0.48	NA 0.04	0.58 NA 0.00	0.26 0.26 0.04	1.19 NA 0.07	NA 0.00	0.40 0.40 0.06	1.97 NA 0.10	1.38 NA 0.00	0.59 0.59 0.09	1.41 NA 0.06	1.05 NA 0.00	0.36 0.36 0.06	2.69 NA	NA 0.00	0.35 0.35	3.70 NA	3.18 NA 0.00	0.53 0.53 0.08	4.76 NA 0.13	NA 0.01	0.79 0.79 0.13	NA 0.05	NA 0.00	0.33 0.33 0.05	1,41 NA 0.03	1.20 NA 0.00	021 021 003	AN 53	0.21 NA	American Medical Association. All Rights
Physi- Non- cian Facility Facility Mai- Work, PE. PE. Praedica	0.59 0.59 0.09	4.56 6.92 NA 0.29	0.00 NA 0.01	4.56 1.73 1.73 0.27	g 0.00 0.00 NA 0.00	0.00 NA 0.00	0.00 0.00 0.00	0.62 1.09 NA 0.04	0.86 NA 0.00	0.24 0.24 0.04	51.05 NA 0.50	0.00 48.03 NA 0.02	7.99 3.02 3.02 0.48	0.70 0.85 NA 0.04	0.00 0.58 NA 0.00	0.70 0.26 0.26 0.04	d 1.05 1.19 NA 0.07	0.79 NA 0.00	0.40 0.40 0.06	1.56 1.97 NA 0.10	1.38 NA 0.00	0.59 0.59 0.09	1.41 NA 0.06	1.05 NA 0.00	0.95 0.36 0.36 0.06	imp 0.93 2.69 NA	2.34 NA 0.00	0.35 0.35	3.70 NA	3.18 NA 0.00	0.53 0.53 0.08	4.76 NA 0.13	3.96 NA 0.01	0.79 0.79 0.13	0.78 NA 0.05	0.00 0.45 NA 0.00	0.87 0.33 0.05	0.54 1.41 NA 0.03	0.00 NA 0.00	0.54 0.21 0.03	0.84 0.53 NA	0.00 0.21 NA	descriptions only are copyright 2009 American Medical Association. All Rights
Physi- Non- cian Facility Facility Mai- Work, PE. PE. Praedica	RVUs** RVUs** RVUs** RVUs**** (4.56 6.92 NA 0.29	Set radiation therapy field 0.00 5.19 NA 0.01	Set radiation therapy field 4.56 1.73 1.73 0.27	Radiation therapy planning 0.00 0.00 NA 0.00	Radiation therapy planning 0.00 0.00 NA 0.00	000 000 000	Radiation therapy dose plan 0.62 1.09 NA 0.04	0.00 0.86 NA 0.00	Radiation therapy dose plan 0.62 0.24 0.24 0.04	Radiotherapy dose plan, imrt 7.99 51.05 NA 0.50	0.00 48.03 NA 0.02	Radiotherapy dose plan, imrt 7.99 3.02 3.02 0.48	Teletx isodose plan simple 0.70 0.85 NA 0.04	Teletx isodose plan simple 0.00 0.58 NA 0.00	Teletx isodose plan simple 0.70 0.26 0.26 0.04	Teletx isodose plan intermed 1.05 1.19 NA 0.07	Teletx isodose plan intermed 0.00 0.79 NA 0.00	Teletx isodose plan intermed 1.05 0.40 0.40 0.06	1.56 1.97 NA 0.10	Teletx isodose plan complex 0.00 1.38 NA 0.00	Teletx isodose plan complex 1.56 0.59 0.59 0.09	Special teletx port plan 0.95 1.41 NA 0.06	Special teletx port plan 0.00 1.05 NA 0.00	Special teletx port plan 0.95 0.36 0.36 0.06	imp 0.93 2.69 NA	Brachytx isodose calc simp 0.00 2.34 NA 0.00	0.93 0.35 0.35	1.39 3.70 NA	0.00 3.18 NA 0.00	Brachytx isodose calc interm 1.39 0.53 0.53 0.08	I 2.09 4.76 NA 0.13	Brachytx isodose plan compl 0.00 3.96 NA 0.01	Brachytx isodose plan compl 2.09 0.79 0.79 0.13	0.87 0.78 NA 0.05	Special radiation dosimetry 0.00 0.45 NA 0.00	0.87 0.33 0.05	Radiation treatment aid(s) 0.54 1.41 NA 0.03	Radiation treatment aid(s) 0.00 1.20 NA 0.00	Redistion treatment aid(s) 0.54 0.71 0.71 0.03	Dediction transformant sides 0.84 0.53 NA	0.00 0.21 NA	odes and descriptions only are copyright 2009 American Medical Association. All Rights
Physi- Non- cian Facility Facility Mai- Work, PE. PE. Praedica	Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3,4} (Set adjation therapy field 1.56 (0.59 (0.59 (0.09))	Set radiation therapy field 4.56 6.92 NA 0.29	Set radiation therapy field 0.00 5.19 NA 0.01	Set radiation therapy field 4.56 1.73 1.73 0.27	Radiation therapy planning 0.00 0.00 NA 0.00	Radiation therapy planning 0.00 0.00 NA 0.00	C Radiation therapy planning 0.00 0.00 0.00 0.00	Radiation therapy dose plan 0.62 1.09 NA 0.04	A Radiation therapy dose plan 0.00 0.86 NA 0.00	Radiation therapy dose plan 0.62 0.24 0.24 0.04	Radiotherapy dose plan, imrt 7.99 51.05 NA 0.50	A Radiotherapy dose plan, imrt 0.00 48.03 NA 0.02	A Radiotherapy dose plan, irart 7.99 3.02 3.02 0.48	A Teletx isodose plan simple 0.70 0.85 NA 0.04	Teletx isodose plan simple 0.00 0.58 NA 0.00	A Teletx isodose plan simple 0.70 0.26 0.26 0.04	Teletx isodose plan intermed 1.05 1.19 NA 0.07	Teletx isodose plan intermed 0.00 0.79 NA 0.00	A Teletx isodose plan intermed 1.05 0.40 0.40 0.06	A Teletx isodose plan complex 1.56 1.97 NA 0.10	Teletx isodose plan complex 0.00 1.38 NA 0.00	A Teletx isodose plan complex 1.56 0.59 0.59 0.09	Special teletx port plan 0.95 1.41 NA 0.06	Special teletx port plan 0.00 1.05 NA 0.00	A Special teletx port plan 0.95 0.36 0.36 0.06	A Brachytx isodose cale simp 0.93 2.69 NA	Brachytx isodose calc simp 0.00 2.34 NA 0.00	Brachytx isodose cale simp 0.93 0.35 0.35	Brachytx isodose calc interm 1.39 3.70 NA	A Brachytx isodose calc interm 0.00 3.18 NA 0.00	A Brachytx isodose calc interm 1.39 0.53 0.53 0.08	Brachytx isodose plan compl 2.09 4.76 NA 0.13	A Brachytx isodose plan compl 0.00 3.96 NA 0.01	Brachytx isodose plan compl 2.09 0.79 0.79 0.13	Special radiation dosimetry 0.87 0.78 NA 0.05	Special radiation dosimetry 0.00 0.45 NA 0.00	A Special radiation dosimetry 0.87 0.33 0.05	A Radiation treatment aid(s) 0.54 1.41 NA 0.03	A Radiation treatment aid(s) 0.00 1.20 NA 0.00	Redistion treatment aid(s) 0.54 0.71 0.71 0.03	A Dadiation transment aid(c) 0.84 0.53 NA	0.00 0.21 NA	codes and descriptions only are copyright 2009 American Medical Association. All Rights

Reserved.

I values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality returning from the chiroprastic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding. Reserved.

Trigules are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payanent.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payanent.

*Global totals for malpractice RVUs may not sum due to rounding.

Facility Mal- PE Practice	0.54	NA 0.20	NA 0.01	1.24 0.19	NA 0.31	NA 0.01	1.86 0.29	1.86 0.06	1.40 0.00	0.46 0.06	NA 0.06	NA 0.00	0.39 0.06	NA 0.00	NA 0.00	0.00	NA 0.01	900 SO	000 AN	V V	0.08 0.01	NA 0.01	NA 0.00	0.10 0.01	NA 0.03	NA 0.00	NA 0.03	NA 0.00	0.15 0.03	NA 0.02	NA 0.00	NA 003	NA 0.00	0.13 0.03	NA 0.05	NA 0.00	0.17 0.05	40.00 AV	7 NA 0.00 XXX	sociation. All Rights	these values have been	payment.	ed in the files used for	
Physic Non- cian Facility Work PE	1			3.25 1.2																							0.50 2.5									0.00 4.40			0.00 5.97	9 American Medical As	dicare, please note that t	e not used for Medicare	tion will only be reflect	
	Description If the bracket 1 channel	Hdr hrachytx 2-12 channel	Hdr brachyty 2-12 channel	Hdr brachytx, 2-12 channel	Hdr brachytx over 12 chan	Hdr brachytx over 12 chan	Hdr brachytx over 12 chan	Apply surface radiation	Apply surface radiation	Apply surface radiation	Radiation handling	Radiation handling	Radiation handling	Radium/radioisotope therapy	Radium/radioisotope therapy	Radium/radioisotope therapy	Inyroid, single uptake	I byroid, single uptake	Thursid multiple untakes	Theroid multiple uptakes	Thyroid, multiple uptakes	Thyroid suppress/stimul	Thyroid suppress/stimul	Thyroid suppress/stimul	Thyroid imaging with uptake	I hyroid imaging with uptake	Thyroid imaging with uptake	Thyroid image, mult uptakes	Thyroid image, mult uptakes	Thyroid imaging	I byroid imaging	Thyroid imaging with flow	Thyroid imaging with flow	Thyroid imaging with flow	Thyroid met imaging	Thyroid met imaging	Thyroid met imaging	Thyroid met imaging/studies	Thyroid met imaging/studies	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	xeserveu. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. Its hudget neutrality reduction from the chirowactic demonstration is not reflected in the RVI is for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Aedicare payment.
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	Nod Nod		,	36		TC	26		TC	26		IC	26		•	56		2 2			26		TC	26	1	2 %	97	TC	26		2 %	3	IC	36		TC	70		JC .	CPT	2 If value	stable 3 The	codes	Medic
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	Global	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	X	XXX	XXX	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	060	XXX	XXX			_	-	
Mal- Practice	RVUs".	000	000	000	0.10	0.00	0.09	0.34	0.01	0.33	0.09	0.00	60'0	0.13	0.01	0.12	0.07	0.00	0.0	100	0.29	0.24	0.01	0.23	0.36	0.02	0.34	0.02	0.51	0.34	0.01	0.54	0.03	0.52	0.72	0.03	89.0	0.09	0.00	ghts	peen	VI is for CP	d for	
Facility PE	RVUs ^{2,3}	900	000	000	Ϋ́	Y.	09.0	YZ.	VA	0.78	NA	ΝĄ	09.0	NA	NA	0.80	Y:	A S	4.43	254	18	5.84	4.43	1.41	7.22	5.06	01.7	6.57	3.20	6.39	4.74	7.50	4.87	2.72	10.84	6.63	4.21	NA	NA	Association. All Rights	alues have	ent.	he files used	
Non- Facility PE	RVUs ^{2, 3}	8.6	8 9	0.00	60.6	8.49	0.60	26.47	25.70	0.78	14.91	14.32	0.60	23.01	22.21	0.80	12.54	1.97	0.38	. 5	1.87	5.84	4.43	1.41	7.22	5.06	01.7	6.57	3.20	6.39	4.74	60.7	4.87	7.72	10.84	6.63	4.21	3.29	2.75	cal Associat	that these	dicare paym	effected in 1	
Physi- cian Work	RVUs.	000	90.0	0:00	1.56	0.00	1.56	2.09	0.00	2.09	1.56	0.00	1.56	2.09	0.00	2.09	1.56	0.00	1.30	t6:+	4.94	3.82	0.00	3.82	5.73	0.00	5.73 8.60	0.00	8.60	4.67	0.00	74.0	000	7.49	11.23	0.00	11.23	1.42	0.00	9 American Medi	dicare, please not	re not used for Me	tic demonstration ction will only be	
	Description	Proton trint, simple w/o comp	Proton dans, sample w/comp	Proton treatment complex	Honerhermia freatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthermia treatment	Hyperthennia treatment	Hyperthermia treatment	Hyperthermia treatment	Hypermea treament	Influe rationality materials	Influence radioactive materials	Apply intreav radiat simple	Apply intreav radiat simple	Apply intrcav radiat simple	Apply intreav radiat interm	Apply intreav radiat interm	Apply intreav radial interm	Apply intreav radiat compl	Apply intreav radiat compl	Apply interstit radiat simpl	Apply interstit radiat simpl	Apply interstit radiat simpl	Apply interstit radiat inter	Amply interestit radiat inter	Apply interstit radiat compl	Apply interstit radiat compl	Apply interstit radiat compl	Hdr brachytx, 1 channel	Hdr brachytx, 1 channel	CPT codes and descriptions only are copyright 2009 American Medical	eserved. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment.	I he bugget neutrality reduction from the chiropractic demonstration is not redected in the files used for codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Aedicare payment.
	Status	ې د	ی ر	ى ر) Δ	4 nz	· ~	· ~	· 24	~	æ	2	~	×	×	~	2	≈ 1	× -	< <	< ∢	¥	Ą	¥	٧	Α.	< <	: ≺	٧	٧	∢ ·	∢ •	< ⊲		: ∢	<	٧	Ą	Ą	codes and	ed. ues are refl	shed as a c.	ndget neut 18940, 989	Medicare payment
	Mod					2	56	2	2	56		2	56		22	56		ည	70	Ç	2 %	i	2	56		1C	56	C	56		22 ;	97	Ţ	, 4	2	JC	56		IC	CPT	Reserved. FIf values	tablis	des 9	edica
	HCPCS																											•			•									- 1	∝	S	. 5	Ž.

Column C		Ģ	×	×	×	*	~	~	~	^	~	^	~	×	~	^	~	~	^	^	*	^	~	^	~	^ '	~ :	^ '	۰,	` '	^ ;	^ '	~ /	` '	` '	` '	` '	` '	` '	^ '	^ :	^ '	^	^		
Name State Description Physiol Physi	7	Practice RVUs ^{2,3,4}	0.04	0.05	0.00	0.04	0.04	0.00	0.04	0.02	0.00	0.02	90.0	0.00	90.0	40.0	0.00	0.04	60.0	0.00	60.0	0.00	0.00	0.00	0.04	0.00	0.04	0.02	0.00	0.02	0.05	0.00	0.05	900	0.00	0.06	0.03	0.00	0.03	0.03	0.00	0.03	0.03	000	ights	
Name State Description Physiol Physi	Till Ce	PE RVUs ^{2,3}	0.19	ΝA	NA	0.20	Y Y	Ϋ́Z	0.18	Y V	Ϋ́	0.11	NA	N A	0.40	Y V	NA	0.19	Z V	NA	0.33	Y Z	Y.	0.00	ΥN	Y.	0.12	¥.	YZ :	0.12	¥.	Y.	0.19	ς . Σ. Σ	S.S.	0.28	V.	Y.	0.14	Y.	NA	0.16	K.	Y.	ation. All R	
Name State Description Physiol Physi	Non-	RVUs ^{2,3}	0.19	7.88	7.68	0.20	2.47	2.29	0.18	4.57	4.46	0.11	6.17	8.78	0.40	9. 20.	2.85	0.19	7.60	7.26	0.33	0.00	0.00	0.00	4.29	4.17	0.12	4.36	4.24	0.12	4.50	4.31	0.19	7.63	5.5	0.28	4. IX	4,04	0.14	2.38	2.22	0.16	2.58	2.44	lical Associa	
Name State Description Physiol Physi	Physi-	Work RVUs ^{2,3}	0.61	0.64	0.00	0.64	0.61	0.00	19.0	0.40	0.00	0.40	1.09	0.00	1,09	19.0	0.00	19.0	1.20	0.00	1.20	0.00	0.00	0.00	0.44	0.00	0.44	0.51	0.00	0.51	0.71	0.00	0.71	0.96	0.00	0.96	0.49	0.00	0.49	0.57	0.00	0.57	0.49	0.00	American Mec	
Name State Description Physiol Physi		Description	Red cell survival study	Red cell survival kinetics	Red cell survival kinetics	Red cell survival kinetics	Red cell sequestration	Red cell sequestration	Red cell sequestration	Spleen imaging	Spleen imaging	Spleen imaging	Platelet survival, kinetics	Platelet survival, kinetics	Platelet survival, kinetics	Platelet survival	Platelet survival	Platelet survival	Lymph system imaging	Lymph system imaging	Lymph system imaging	Blood/lymph nuclear exam	Blood/lymph nuclear exam	Blood/lymph nuclear exam	Liver imaging	Liver imaging	Liver imaging	Liver imaging with flow	Liver imaging with flow	Liver imaging with flow	Liver imaging (3D)	Liver imaging (3D)	Liver imaging (3D)	Liver image (3d) with flow	Liver image (3d) with flow	Liver image (3d) with flow	Liver and spleen imaging	Liver and spleen imaging	Liver and spleen imaging	Liver & spleen image/flow	Liver & spleen image/flow	Liver & spleen image/flow	Liver function shidy	Liver function study	descriptions only are copyright 2009	
Name State Description Physiol Physi		Status	٧	4	A	٧	<	∢	٧	A	∢	¥	٧	¥	٧	4	Y	٧	K	٧	¥	၁	ပ	ပ	¥	4	¥	¥	¥	₹	Ą	Ą	٧	∢ .	Κ.	∢	∀	٧	¥	¥	٧	¥	¥	¥	odes and	-ci
Mod States Description Physic According to the company of the company o		Po W	56		10	56		IC	56		TC	56		C	56		C	56		IC	26		JC.	56		TC	56		JC	56		C	56	8	2	56		ပ္	26		ည	56		일.	CPIC	Reserve
Mod Status		CPT ^{1,3} / HCPCS	78130	78135	78135	78135	78140	78140	78140	78185	78185	78185	78190	78190	78190	78191	78191	18191	78195	78195	78195	78199	78199	78199	78201	78201	78201	78202	78202	78202	78205	78205	78205	78206	78206	78206	78215	78215	78215	78216	78216	78216	78220	78220		
Mod Status																																														
Mod Status Description North Facility Facility Class Facility Class		Global	XXX	XXX	XXX	XXX	222	222	222	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XXX	XX	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX	XXX										
~10	i	Practice RVUs ^{2.3,4}	0.03	0.05	00.0	0.05	0.03	0.00	0.03	0.05	0.00	0.05	0.05	0.00	0.05	0.00	0.00	0.00	0.03	0.00	0.03	0.05	0.00	0.05	90.0	0.00	90.0	0.01	0.00	0.01	10.0	0.00	10.0	0.01	0.00	0.01	0.01	0.00	10.0	0.02	0.00	0.02	0.04	0.00	ights	
~10		PE PE RVUs ^{2,3}	0.11	AN	N A	0.22	1.42	1.28	0.14	NA	Ϋ́Z	0.23	NA	NA	0.18	ΥN	ďZ	0.00	NA	NA	0.14	NA	Ν	0.19	ΥZ	NA	0.21	NA	Ϋ́	90:0	Y Y	Ϋ́Z	0.04	NA	Y Z	90.0	ΥZ	ΝĄ	0.04	NA	NA	0.10	NA	NA	ation. All R	
~10	Non	PE PE RVUs ^{2,3}	0.11	6.77	6.55	0.22	1,42	1.28	0.14	2,92	2.69	0.23	9.64	9.45	0.18	0.00	0.00	0.00	3.49	3.36	0.14	4.59	4.39	0.19	5.22	5.00	0.21	1.88	1.82	90.0	1.53	1.50	0.04	1.70	1.64	90'0	1,42	1.38	0.04	1.74	1,64	0.10	3.06	2.87	edical Assoc	
~10	Physi-	Work RVUs ^{2,3}	0.82	0.86	00.00	0.86	09.0	00'0	09'0	0.82	0.00	0.82	0.74	0.00	0.74	0.00	0.00	00.00	0.55	00:0	0.55	0.75	0.00	0.75	080	0.00	08'0	0.19	0.00	0.19	0.22	0.00	0.22	0.23	0.00	0.23	0.32	0.00	0.32	0.45	00:00	0.45	19:0	0.00	American M	
~10		Description	Thyroid met imaging/studies	Thyroid met imaging, body	Thyroid met imaging, body	Thyroid met imaging, body	Thyroid met uptake	Thyroid met uptake	Thyroid met uptake	Parathyroid nuclear imaging	Parathyroid nuclear imaging	Parathyroid nuclear imaging	Adrenal nuclear imaging	Adrenal nuclear imaging	Adrenal nuclear imaging	Endocrine nuclear procedure	Endocrine nuclear procedure	Endocrine nuclear procedure	Bone marrow imaging, Itd	Bone marrow imaging, Itd	Bone marrow imaging, hd	Bone marrow imaging, mult	Bone marrow imaging, mult	Bone marrow imaging, mult	Bone marrow imaging, body	Bone marrow imaging, body	Bone marrow imaging, body	Plasma volume, single	Plasma volume, single	Plasma volume, single	Plasma volume, multiple	Plasma volume, multiple	Plasma volume, multiple	Red cell mass, single	Red cell mass, single	Red cell mass, single	Red cell mass, multiple	Red cell mass, multiple	Red cell mass, multiple	Blood volume	Blood volume	Blood volume	Red cell survival study	Red cell survival study	descriptions only are copyright 2009	
~10		Status	V	4	. ⋖	<	<	4	<	< <	V	< <	. <	< <	4	O	Ü	U	¥	٧	V	*	4	٧	٧	Ą	A	٧	٧	¥	<	∢	V	V	K	K	∢	∀ ,	ĸ	<	∢	Α.	٧	Ą	des and	
~10					IC	56		IC	26		20	26	ì	TC	56	i	JC	26		77	26		TC	56		TC	26		1C	56		JC	56		10	56		C	26		JC	56		C	CPT co	Reserved
		CPT ^{1,2} /	78016	78018	78018	78018	78020	78020	78020	78070	78070	78070	78075	78075	78075	78099	78099	78099	78102	78102	78102	78103	78103	78103	78104	78104	78104	78110	78110	78110	78111	78111	78111	78120	78120	78120	78121	78121	78121	78122	78122	78122	78130			

Reserved.

I readures are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neumatily reduction from the chiropractic demoistration is not reflected in the R.VUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R.VUs may not sum due to rounding.

Reserved.

The should be countried for codes not payable by Medicare, please note that these values have been established as a countriety to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 89840, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

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ž	Practice RVUs ^{2,3,7}	0.05	90.0	0.00	9000	0.00	0.00	0.04	0.00	0.0	0.05	0.00	0.05	00:0	0.00	0.00	0.07	9 6	0.07	000	90.0	0.01	0.00	0.01	0.02	0.00	0.00	0.00	0.00	0.02	0.00	0.04	0.03	0.00	0.03	0.05	0.00	0.05	0.05	ights	5	been	Vils for Cl	od for	
Facility	RVUs ²³	0.20	KZ	Y ;	0.24	Ϋ́	00'0	ΝA	ΥZ	0.19	¥ Z	Y Z	47.0	<u> </u>	Z Z	0.25	K Z	4 o	NA N	Z Z	0.28	ΝĄ	ΥN	80.0	7. N	Y.	0.00	NA	Y S	_ v	N.	0.21	NA	NA	0.13	Y Z	NA	0.34	ΥN	tion. All R.	1	values have	nent. eted in the R	the files use	
Non- Facility	RVUs ^{2,3}	0.20	5.38	5.14	0.24	0.00	00.00	3.73	3.54	61.0	4.86	4.62	6.24	07.0	5.02	0.25	84.1	07.0	4 56	4.28	0.28	0.58	0.50	0.08	4 S	00.0	0.00	00.0	0.00	4.01	3.81	0.21	3.71	3.59	0.13	7.26	6.93	0.34	4.08	ical Associa	!	e that these	dicare payn is not reflec	reflected in	
Physi-	Work RVUs ^{2,3}	89.0	0.88	0.00	88.0	0.00	0.00	0.62	0.00	0.62	0.83	0.00	0.83	0.80	0.00	0.86	70.1	90.0	1.04	000	1.04	0.22	0.00	0.22	0.30	0.00	0.00	0.00	000	24.0 85.0	0.00	0.78	0.49	0.00	0.49	1.00	0.00	00.1	0.77	merican Med	i	re, please not	ot used for Me Jemonstration	will only be	:
	Description	MeckelÆs diven exam	Leveen/shunt patency exam	Leveen/shunt patency exam	Leveen/shunt patency exam	Gi nuclear procedure	GI nuclear procedure	Bone imaging, limited area	Bone imaging, limited area	Bone imaging, limited area	Bone imaging, multiple areas	Bone imaging, multiple areas	Sone imaging, multiple areas	Bone imaging, whole body	Bone imaging, whole body	Bone imaging, whole body	Sone imaging, 3 phase	Bone imaging, 5 puase	Bone imaging, 3 picase Rone imagina (1D)	Bone imaging (3D)	Bone imaging (3D)	Bone mineral, single photon	Bone mineral, single photon	Bone mineral, single photon	Bone mineral, dual photon Musculoskalatal michar exam	Musculoskeletal nuclear exam	Musculoskeletal nuclear exam	Non-imaging heart function	Non-imaging heart function	Non-imaging near innertion Cardiar churt imagino	Cardiac shunt imaging	Cardiac shunt imaging	Vascular flow imaging	Vascular flow imaging	Vascular flow imaging	Acute venous thrombus image	Acute venous thrombus image	Acute venous thrombus image	Venous thrombosis imaging	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	9	if values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chirometric demonstration is not reflected in the RVIIs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	dedicare payment.
	Status	4	¥	<	∢ (, O	O	<	¥	∢	4	۷,	۲ -	< -	< -	∢ .	∢ -	< <	< ∢	: <	<	z	z	z;	z C	ن	C	Ų.	υ.	< ⊲	: ≺	Y	٧	¥	4	Y	¥	Ą	٧	des and	1.4	s are ref	ed as a c leet neur	940,989	paymen
	Mod	26		72	97	10	26		TC	56		ဥ ႏ	97	ç	2 ;	97	٤	۲ کر	04	TC	26		7	56		JC	56		2 5	07	TC	56		77	26		TC	56		CPT cox	Reserved	if value	stablishe The bud	odes 986	Medicare payment
	CPT ^{4,3} / HCPCS	78290	18291	78291	78291	78299	78299	78300	78300	78300	78305	78305	76303	/8300	78506	78306	70215	78215	78420	78320	78320	78350	78350	78350	78300	78399	78399	78414	78414	78478	78428	78428	78445	78445	78445	78456	78456	78456	78457	-	24	2	ŭ.m	ō	~
	Global	xxx	XXX	XXX	XXX	XXX	XXX	xxx	XXX	XXX	xxx	XXX	XXX	YYY	XXX	XXX	XX	YYY	S X	XXX	xxx	KXX	XX	XXX	YYY	XX	XX	XXX	XXX	XXX	xxx	XXX	xxx	XXX	xxx	XXX	XXX	XXX	XX						
Z -	_	•		_		, ,,	٠,	-	-			• •	` '	,	,														~ ,	` ^	. ^	•		^		~		\sim	•						
	ractice VUs ²³	0.03	90.0	0.00	0.05	0.00	0.03	0.02	0.00	0.02	0.03	0.00	0.03	90.04	000														0.01	10:01	0.01	0.07	0.00	0.07	00.0	0.00							for CPT		
≥	a. Éz															0.04	0.03	0.00	50.0	000	0.03	0.05	0.00	0.05	0.00	0.01	0.01	0.00									0.03	0.05	000	II Rights	ì	save been	he RVUs for CPT	used for	
Facility	PE Practice RVUs ²³ RVUs ²³															0.04	0.03	0.00	50.0	000	0.03	0.05	0.00	0.05	0.00	0.01	0.01	0.00					NA 0.00					0.05	000	ation. All Rights	,	values bave been	ment.	the files used for	
_		0.14	NA	¥ Z	0.24	Y X	0.14	V Z	NA V	0.16	¥	Y S	0.00	NA V	AN S	0.24 0.04	NA 0,03	000	NA 0.03	000 AN	0.19 0.03	NA 0.05	NA 0.00	0.05	NA 0:01	0.06 0.01	NA 0.01	NA 0.00	0.07	K V	0.08	NA	NA NA	0.28	ΝA	N.	0.12 0.03	NA 0.05	NA 0.00	edical Association. All Rights		ote that these values bave been	Aedicare payment. In is not reflected in the RVUs for CPT	e reflected in the files used for	
_	RVUs ^{2,3} RVUs ^{2,3} F	0.14	7.48 NA	7.23 NA	0.24	3.53 NA	0,14 0,14	2.44 NA	2.28 NA	0.16 0.16	1.84 NA	1.77 NA	0.06	5.22 NA	4.9/ NA	0.24 0.24 0.04	5.40 NA 0.03	000	5.33 NA 0.03	5.13 NA 0.00	0.19 0.19 0.03	6.23 NA 0.05	6.01 NA 0.00	0.22 0.22 0.05	NA 0:01	0.06 0.00	2.03 NA 0.01	1.96 NA 0.00	0.07	K V	80:0	7.51 NA	NA NA	0.28	0.00 NA	0.00 NA	0.12 0.12 0.03	NA 0.05	7.24 NA 0.00	American Medical Association. All Rights		care, please note that these values bave been	not used for Medicare payment. demonstration is not reflected in the RVUs for CPT	on will only be reflected in the files used for	
Non- Facility	PE PE PE RVUs ^{2,3} F	0.49 0.14 0.14	0.84 7.48 NA	0.00 7.23 NA	0,24 0,24 3.67 MA	0.00 3.53 NA	0.45 0.14 0.14	0.52 2.44 NA	0.00 2.28 NA	0.52 0.16 0.16	0.47 1.84 NA	0.00 1.77 NA	am 0.47 0.06 0.06	0.74 5.22 NA	0.00 4.97 NA	y 0.74 0.24 0.24 0.04	0.69 5.40 NA 0.03	5.19 to 10.00	2.00 0.21 0.22 0.03	0.00 5.13 NA 0.00	0.68 0.19 0.19 0.03	0.78 6.23 NA 0.05	0.00 NA 0.00	0.78 0.22 0.22 0.05	1.73 NA 0.01	0.20 0.06 0.06 0.01	0.20 2.03 NA 0.01	0.00 NA 0.00	0.20 0.07 0.07	1.08 AN 07.1	0.27 0.08 0.08	NA 7.51 NA	0.00 7.23 NA	0.28 0.28	0.00 NA	0.00 0.00 NA	0.38 0.12 0.12 0.03	7.44 NA 0.05	0.00 7.24 NA 0.00	lescriptions only are copyright 2009 American Medical Association. All Rights		ected for codes not payable by Medicare, please note that these values bave been	ourtesy to the general public and are not used for Medicare payment. This production from the chiromactic demonstration is not reflected in the RVHs for CPT	11, and 98942. The required reduction will only be reflected in the files used for	
Non- Facility	Work PE PE Description RVUs ^{2,3} RVUs ^{2,3} R	0.49 0.14 0.14	0.84 7.48 NA	Hepatobiliary unaging 0.00 7.23 NA	0.84 0.24 0.24	Salivary gland imaging 0.00 3.53 NA	Salivary gland imaging 0.45 0.14 0.14	0.52 2.44 NA	Serial salivary imaging 0.00 2.28 NA	Serial salivary imaging 0.52 0.16 0.16	Salivary gland function exam 0.47 1.84 NA	Salivary gland function exam 0.00 1.77 NA	Salivary gland function exam 0.47 0.00 0.00	Esophageal motility study 0.74 5.22 INA	Esophageal motility study 0.00 4.97 NA	Esophageal motility study 0.74 0.24 0.24 0.04	Castric mucosa unaging 0.69 5.40 NA 0.03	Castric mucosa magnig 0.00 5.19 14A 0.00	0.07 0.41 0.21 0.03	Gastroesonhageal reflux exam 0.00 \$.13 NA 0.00	Gastroesophageal reflux exam 0.68 0.19 0.19 0.03	Gastric emptying study 0.78 6.23 NA 0.05	Gastric emptying study 0.00 6.01 NA 0.00	Gastric emptying study 0.78 0.22 0.25	0.50 NA 0.01 0.00 NA 0.00	Vit B-12 absorption exam 0.20 0.06 0.06 0.01	0.20 2.03 NA 0.01	Vit b-12 absrp exam, int fac 0.00 1.96 NA 0.00	0.20 0.07 0.07	0.27 1.88 NA	Vit B-12 absorp, combined 0.27 0.08 0.08	0.99 7.51 NA	0.00 7.23 NA	0.99 0.28 0.28	0.00 0.00 NA	0.00 0.00 NA	0.38 0.12 0.12 0.03	. 0.68 7.44 NA 0.05	Meckel-Es divert exam 0.00 7.24 NA 0.00	les and descriptions only are copyright 2009 American Medical Association. All Rights		are reflected for codes not payable by Medicare, please note that these values bave been	d as a courtesy to the general public and are not used for Medicare payment. not neutrality reduction from the chiromactic demonstration is not reflected in the RVUs for CPT	40, 98941, and 98942. The required reduction will only be reflected in the files used for	payment.
Non- Facility	Work PE PE RVUe ^{2,3} RVUe ^{2,3} F	Liver function study 0.49 0.14 0.14	Hepatobiliary imaging 0.84 7.48 NA	A Hepatobiliary imaging 0.00 7.23 NA	Hepatobulary unaging 0.84 0.24 0.24	Salivary gland imaging 0.00 3.53 NA	A Salivary gland imaging 0.45 0.14 0.14	Serial salivary imaging 0.52 2.44 NA	A Serial sativary imaging 0.00 2.28 NA	Serial salivary imaging 0.52 0.16 0.16	A Salivary gland function exam 0.47 1.84 NA	A Salivary gland function exam 0.00 1.77 NA	Salivary gland function exam 0.47 0.00 0.00	A Esophageal motility study 0.74 5.22 INA	A Esophageal motility study 0.00 4.97 NA	Esophageal motility study 0.74 0.24 0.24 0.04	A Gastric mucosa imaging 0.69 5.40 NA 0.03	Castric mucosa magnig 0.00 5.19 14A 0.00	A Gaetrosconbaneal reflux exam 0.68 5.33 NA 0.03	Gastroesonhageal reflux exam 0.00 \$.13 NA 0.00	A Gastroesophageal reflux exam 0.68 0.19 0.19 0.03	Gastric emptying study 0.78 6.23 NA 0.05	A Gastric emptying study 0.00 6.01 NA 0.00	Gastric emptying study 0.78 0.22 0.25	Vit B-12 absorption exam 0.20 1.75 NA 0.01	A Vit B-12 absorption exam 0.20 0.06 0.06 0.01	0.20 2.03 NA 0.01	A Vit b-12 absrp exam, int fac 0.00 1.96 NA 0.00	Vit b-12 absrp exam, int fac 0.20 0.07 0.07	Vit B-12 absorp, combined 0.2/ 1.88 NA Vit B-17 shown combined 0.00 1.70 NA	A Vit B-12 absorp, combined 0.27 0.08 0.08	A Acute GI blood loss imaging 0.99 7.51 NA	A Acute GI blood loss imaging 0.00 7.23 NA	A Acute GI blood loss imaging 0.99 0.28 0.28	C Gi proteín loss exam 0.00 0.00 NA	GI protein loss exam 0.00 0.00 NA	A GI protein loss exam 0.38 0.12 0.12 0.03	MeckelÆs divert exam 0.68 7.44 NA 0.05	MeckeLEs divert exam 0.00 7.24 NA 0.00	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved.	ly values are reflected for codes not payable by Medicare, please note that these values bave been	established as a courtesy to the general public and are not used for Medicare payment. The hudget neutrality reduction from the chiromactic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.

8 6 0000 0000 0000 0000 0000 0000 0000	Status	Description	Physi- cian Work RVUs ^{2,3}	Non- Facility PE RVUs 23	Facility PE RVUs ²³	Mal- Practice RVUs ^{2.3,4}	Global	CPT ^{t-3} l HCPCS	Mod	Status	Description	rnyst- clan Work RVUs ²³	Facility PE RVUs ^{2,3}	Facility PE RVUs ^{2,3}	Mal- Practice RVUs ^{2,3,4}	Global
	Venous thrombosis imaging	imaging	0.00	3.85	A S	0.00	XXX	78481	22 %	∢ •	Heart first pass, single	0.00	3.35	NA 0.33	0.00	X
NA	Venous thrombosis i	maging	0.77	0.23	0.23	0.03	YYY	78481	07	₹ .	Heart first pass, smgle	0.70	0.53	0.33	60.0	3
2.7. Color Color <th< th=""><th>Ven thrombosis una</th><th>es, bilat</th><th>0.00</th><th>3.43</th><th>K Z</th><th>0.00</th><th>XXX</th><th>78483</th><th>T.</th><th>< 4</th><th>ricari insi pass, munipie Heart first nass, multinle</th><th>000</th><th>4.37</th><th>Ϋ́</th><th>0.00</th><th>ž</th></th<>	Ven thrombosis una	es, bilat	0.00	3.43	K Z	0.00	XXX	78483	T.	< 4	ricari insi pass, munipie Heart first nass, multinle	000	4.37	Ϋ́	0.00	ž
NA 0.00 XXX 7840 C C Heard mange (FeR), sample 0.00 0.00 NA 0.00 NA 0.00 XXX 7840 1.C C Heard mange (FeR), sample 1.05 0.02 NA 0.00 NA 0.00 XXX 78492 1.C C Heard mange (FeR), multiple 1.05 0.00 NA 0.00 NA 0.00 XXX 78492 1.C C Heard mange (FeR), multiple 1.07 0.00 NA 0.00 NA 0.00 XXX 78492 1.C C Heard mange (FeR), multiple 1.07 0.04 0.04 0.00 1.7 0.00 XXX 78492 1.C A Heart mange (FeR), multiple 1.07 0.04 0.04 0.00 0.7 XXX 78492 1.C A Heart mange (FeR), multiple 1.07 0.04 0.04 0.00 0.7 XXX 78492 1.C A Heart mange (FeR), multiple 1.07 0.04 0.04 0.04 0.04	Ven thrombosis imag	es, bilat	0.90	0.20	0.20	0.0	XXX	78483	50	: 4	Heart first pass, multiple	1.47	0.49	0.49	0.07	XXX
0.7. 0.0. <th< th=""><th>Heart muscle imagin</th><th>g (PET)</th><th>00'0</th><th>0.00</th><th>A'N</th><th>0.00</th><th>XXX</th><th>78491</th><th></th><th>O</th><th>Heart image (pet), single</th><th>00:0</th><th>0.00</th><th>Ϋ́</th><th>0.00</th><th>XXX</th></th<>	Heart muscle imagin	g (PET)	00'0	0.00	A'N	0.00	XXX	78491		O	Heart image (pet), single	00:0	0.00	Ϋ́	0.00	XXX
Nat	Heart muscle imaging (PET)	g (PET)	0.00	0.00	N.	0.00	XXX	78491	C	C	Heart image (pet), single	00.0	0.00	N A	0.00	XXX
NA 0.00 XXX 7892 C Heart image (pot), multiple 0.00 0.00 NA 0.00 0.25 0.06 XXX 7892 C A Heart image (pot), multiple 1.87 0.55 0.50 0.00 NA 0.00 NA 0.00 XXX 7894 1.C A Heart image, spect 1.18 0.50 0.44 NA 0.00 0.01 XXX 7894 1.C A Heart image, spect 1.19 0.40 0.00	Heart muscle imaging (PET)	ig (PET)	1.50	0.37	0.37	80.0	XXX	78491	56	V	Heart image (pet), single	1.50	0.42	0.42	0.08	XXX
NA 0.00 XXX 78922 1C C Heart image (pot), multiple 0.00 0.00 NA 0.00 NA 0.00 XXX 78942 A Heart image, spect 110 444 NA 0.00 NA 0.00 XXX 78949 1 A Heart image, spect 110 644 NA 0.00 NA 0.00 XXX 78949 1 A Heart image, spect 110 644 0.64 0.04 0.00 0.44 0.00 XXX 78949 1 A Heart first pass ade-on 0.00 0.04 0.04 0.00 0.44 0.00 XXX 78969 1 C C Cardiovascular mucker ream 0.00 <	Heart muscle blood, single	single	98.0	4.01	NA	90.0	XXX	78492		၁	Heart image (pet), multiple	0.00	0.00	NA	00.0	XXX
NA 0.00 XXX 78492 26 A Heart image, spect 1.19 4.84 NA 0.00 NA 0.00 XXX 78494 1C A Heart image, spect 1.19 4.44 NA 0.00 NA 0.00 XXX 78494 1C A Heart image, spect 1.00 4.44 NA 0.00 NA 0.00 XXX 78496 1C A Heart first pass add-on 0.00 0.48 0.04 0.00 0.44 0.00 XXX 78496 1C A Heart first pass add-on 0.00 0.04 0.00 0.44 0.00 XXX 78499 1C C Cardiovascular modera cann 0.00	Heart muscle blood, single	single	00.0	3.74	N.A	0.00	XXX	78492	TC	၁	Heart image (pet), multiple	0.00	0.00	NA N	0.00	XX
NA 0.00 XXX 78494 A Heart image, spect 1.19 4.84 NA 0.00 NA 0.00 XXX 78494 26 A Heart image, spect 1.19 0.40 0.60 0.00	Heart muscle blood, single	single	0.86	0.27	0.27	90:0	XXX	78492	76	<	Heart image (pet), multiple	1.87	0.55	0.55	0.10	X
NA 0.00 XXX 78494 TC A Heart images, spect 1.00 4.44 NA 0.00 NA 0.00 XXX 78496 26 A Heart first pass add-on 0.00 0.44 0.04 0.04 0.06 0.05 0.04 0.05 </th <td>Heart muscle blood, multiple</td> <td>multiple</td> <td>1.23</td> <td>3.38</td> <td>Ϋ́</td> <td>0.07</td> <td>XXX</td> <td>78494</td> <td></td> <td>٧</td> <td>Heart image, spect</td> <td>61.1</td> <td>4.84</td> <td>¥ :</td> <td>90.0</td> <td>XXX</td>	Heart muscle blood, multiple	multiple	1.23	3.38	Ϋ́	0.07	XXX	78494		٧	Heart image, spect	61.1	4.84	¥ :	90.0	XXX
NA 0.007 XXX XXX X8494 A Heart first pass add-on 1.19 0.40 0.04 0.04 0.04 NA 0.000 XXX X8496 A Heart first pass add-on 0.05 0.04 0.04 0.05 NA 0.000 XXX X8499 C A Heart first pass add-on 0.00 0.04 0.04 0.05 NA 0.000 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.001 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.002 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X8499 C C Cardiovascular nuclear exam 0.00 0.00 0.00 0.00 NA 0.004 XXX X848 C A Lung Perfission inaging 0.04 4.15 NA 0.00 NA 0.004 XXX X848 C A Lung V/Q image single breath 0.09 0.24 0.04 0.00 NA 0.004 XXX X848 C A Lung V/Q image single breath 0.09 0.24 0.00 0.00 NA 0.005 XXX X848 C A Lung V/Q image single breath 0.09 0.24 0.00 0.00 NA 0.007 XXX X848 C A Lung V/Q image single breath 0.09 0.24 0.00 0.00 0.00 NA 0.008 XXX X848 C A Lung V/Q image single breath 0.09 0.24 0.01 0.00 0.0	Heart muscle blood, multiple	multiple	0.00	3.00	Y.	0.00	XXX	78494	ပ္ :	< -	Heart image, spect	00.0	4.	e S	0.00	XXX
NA 0.006 XXX X8496	Heart muscle blood,	multiple	1.23	0.37	0.37	0.02	XXX	78494	56	٧	Heart image, spect	1.19	0.40	0.40	0.06	XXX
NA OAG NAX T8996 TC A Heart first pass add-on 0.00	Heart image (3d), single	ngle	1.09	4.39	Ϋ́	90.0	XXX	78496		<	Heart first pass add-on	0.50	0.64	9.64	0.03	777
0.04 0.05 XXX 789-96 26 A Hearfitz purs added on 0.50 0.50 0.06 0.01 0.00 NA 0.08 XXX 789-99 C Cardiovascular nuclear exam 0.00 0.00 NA 0.00 NA 0.00 XXX 789-99 C Cardiovascular nuclear exam 0.00 <td< th=""><td>Heart image (3d), single</td><td>ngle</td><td>0.00</td><td>4.05</td><td>V.</td><td>0.00</td><td>XXX</td><td>78496</td><td>ည</td><td>4</td><td>Heart first pass add-on</td><td>0.00</td><td>0.48</td><td>0.48</td><td>0.00</td><td>222</td></td<>	Heart image (3d), single	ngle	0.00	4.05	V.	0.00	XXX	78496	ည	4	Heart first pass add-on	0.00	0.48	0.48	0.00	222
NA 0.08 XXX 78499 TC Cardiovascular nuclear exam 0.00 0.00 NA 0.00 0.48 0.07 XXX 78499 1C Cardiovascular nuclear exam 0.00 0.00 NA 0.00 0.48 0.07 XXX 78499 2C Cardiovascular nuclear exam 0.00	Heart image (3d), single	ingle	1.09	0.34	0.34	0.05	XXX	78496	56	∢	Heart first pass add-on	0.50	91.0	91.0	0.02	222
NA 0.00 XXX 78499 TC Cardiovascular nuclear exam 0.00	Heart image (3d), multiple	nultiple	1,46	8.54	ΥZ.	80:0	XXX	78499		ပ	Cardiovascular nuclear exam	0.00	00.0	Ν	0.00	XXX
0.43 0.07 XXX 78499 2.6 C. Cardiovascular nuclear casim 0.00 0.00 0.00 0.00 0.24 0.00 XXX 78380 T. A Lung perfusion imaging 0.74 4.16 NA 0.00 0.22 0.00 XXX 78380 T. A Lung perfusion imaging 0.00 4.16 NA 0.00 NA 0.00 XXX 78384 A Lung perfusion imaging 0.00 2.28 NA 0.00 NA 0.00 XXX 78384 A Lung VQ image single breath 0.90 2.28 NA 0.00 NA 0.00 XXX 78384 A Lung VQ imaging 1.09 7.51 NA 0.00 NA 0.00 XXX 78385 A Lung VQ imaging 1.09 7.21 NA 0.00 NA 0.00 XXX 78385 A A Lung VQ imaging 1.09 7.21 NA 0.00 <td>Heart image (3d), multiple</td> <td>aultiple</td> <td>00'0</td> <td>8.06</td> <td>NA</td> <td>00.0</td> <td>XXX</td> <td>78499</td> <td>7</td> <td>ပ</td> <td>Cardiovascular nuclear exam</td> <td>00'0</td> <td>0.00</td> <td>NA</td> <td>0.00</td> <td>XXX</td>	Heart image (3d), multiple	aultiple	00'0	8.06	NA	00.0	XXX	78499	7	ပ	Cardiovascular nuclear exam	00'0	0.00	NA	0.00	XXX
NA 0.04 XXX 78880 A Lung perfusion imaging 0.74 4.37 NA 0.04 NA 0.03 XXX 78880 1C A Lung perfusion imaging 0.74 4.15 NA 0.04 NA 0.03 XXX 78880 1C A Lung V/O image single breath 0.99 2.28 NA 0.04 NA 0.04 XXX 78884 1C A Lung V/O image single breath 0.99 2.38 NA 0.00 NA 0.04 XXX 78885 1C A Lung V/O image single breath 0.99 2.38 NA 0.00 NA 0.04 XXX 78885 1C A Lung V/O image single breath 0.99 2.38 NA 0.00 NA 0.04 XXX 78885 1C A Lung V/O image single breath 0.99 2.38 NA 0.00 NA 0.04 XXX 7888 1C A <t< th=""><td>Heart image (3d), multiple</td><td>nultiple</td><td>1.46</td><td>0.48</td><td>0.48</td><td>0.07</td><td>XXX</td><td>78499</td><td>56</td><td>၁</td><td>Cardiovascular nuclear exam</td><td>0.00</td><td>0.00</td><td>00'0</td><td>0.00</td><td>XXX</td></t<>	Heart image (3d), multiple	nultiple	1.46	0.48	0.48	0.07	XXX	78499	56	၁	Cardiovascular nuclear exam	0.00	0.00	00'0	0.00	XXX
NA 0.00 XXX 78380 TC A Lung perfusion imaging 0.00 4.16 NA 0.00 NA 0.04 XXX 78384 26 A Lung perfusion imaging 0.74 0.21 0.21 0.04 NA 0.04 XXX 78384 1 Lung V/Q image single breath 0.90 2.28 NA 0.00 NA 0.04 XXX 78384 1 Lung V/Q image single breath 0.90 2.28 NA 0.00 NA 0.04 XXX 78384 1 Lung V/Q image single breath 0.90 2.28 NA 0.00 NA 0.04 XXX 78385 1 Lung V/Q imaging 1.09 7.31 NA 0.00 NA 0.05 XXX 78386 1 A Lung V/Q imaging 1.09 0.31 0.31 0.01 NA 0.05 XXX 78386 1 A Lung V/Q imaging 0.00 2.28 NA 0.00 NA	Heart infarct image		69.0	3.61	NA N	0.04	XXX	78580		٧	Lung perfusion imaging	0.74	4.37	Ϋ́	0.04	XX
0.03 XXX TSSS A Lung perfusion in maging 0.74 0.21 0.21 0.04 NA 0.04 XXX 78584 T Lung V/Q image single breath 0.99 2.38 NA 0.00 0.25 0.04 XXX 78584 TC A Lung V/Q image single breath 0.99 0.30 0.30 0.00 0.24 0.04 XXX 78585 TC A Lung V/Q image single breath 0.99 0.30 0.30 0.00 NA 0.06 XXX 78585 TC A Lung V/Q image single breath 0.99 0.30 0.30 0.00 0.14 0.05 XXX 78585 TC A Lung V/Q image single breath 0.99 0.30 0.30 0.00 0.14 0.05 XXX 7858 TC A Lung V/Q image single breath 0.99 0.30 0.00 0.15 0.16 0.07 XXX 78 TC A Lung V/Q ima	Heart infarct image	e.	0.00	3.40	NA	00:00	XXX	78580	2	٧	Lung perfusion imaging	0.00	4.16	NA V	0.00	XXX
NA 0.04 XXX 78584 A Lung V/Q images single breath 0.99 2.58 NA 0.07 NA 0.04 XXX 78584 TC A Lung V/Q image single breath 0.99 2.28 NA 0.00 0.04 XXX 78584 TC A Lung V/Q image single breath 0.99 2.28 NA 0.00 0.14 XXX 78585 T Lung V/Q imaging 1.09 7.51 NA 0.00 0.15 XXX 78585 Z A Lung V/Q imaging 1.09 7.51 NA 0.00 0.15 XXX 78585 Z A Lung V/Q imaging 1.09 7.51 NA 0.00 NA 0.00 XXX 78586 Z A Acrosol lung image, single breath 0.90 0.31 0.00 0.00 0.01 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Heart infarct image	e)	69'0	0.22	0.22	0.03	XXX	78580	56	∢	Lung perfusion imaging	0.74	0.21	0.21	0.04	XX
NA 0.00 XXX 78544 1C A Lung V/Q images single breath 0.00 2.245 NA 0.00 0.56 0.04 XXX 78584 26 A Lung V/Q imaging 1.09 0.30 0.30 0.00 0.31 0.04 XXX 78585 7C A Lung V/Q imaging 1.09 0.31 0.04 0.30 0.00 0.31 0.04 XXX 78585 2 A Lung V/Q imaging 0.00 7.51 NA 0.00 NA 0.05 XXX 78585 2 A Acrosol lung image, single 0.40 0.12 NA 0.00 NA 0.00 XXX 78586 7 A Acrosol lung image, single 0.40 0.12 NA 0.00 NA 0.00 XXX 78587 7 A Acrosol lung image, single 0.40 0.12 NA 0.00 NA 0.00 XXX 78587 7 <	Heart infarct image (ef)	(el)	0.80	4.29	¥.	0.04	XXX	78584	í	Α,	Lung V/Q image single breath	0.99	2.38	S S	0.07	X X X
V.2.0 0.04 XXX 78344 2.0 A. Lung V/Q imaging entant 0.99 0.50 <th< th=""><td>Heart infarct image (ef)</td><td>c (ef)</td><td>0.00</td><td>4.03 2.03</td><td>Y &</td><td>00.0</td><td>XXX</td><td>78584</td><td><u>)</u> }</td><td>۷.</td><td>Lung V/Q image single breath</td><td>0.00</td><td>87.7</td><td>NA 0</td><td>00.0</td><td>X X</td></th<>	Heart infarct image (ef)	c (ef)	0.00	4.03 2.03	Y &	00.0	XXX	78584	<u>)</u> }	۷.	Lung V/Q image single breath	0.00	87.7	NA 0	00.0	X X
NA	Heart infarct imag	re (et)	0.80	07.0	07:0	5 6	X X	79595	07	۲ <	Lang V.C. image suigie oreau.	00.1	0.20	00 V	00.0	XXX
NA 0.05 XXX 78585 26 A Lung V/Q imaging 1.09 0.31 0.31 0.06 NA 0.05 XXX 78586 A Aerosol lung image, single 0.40 3.67 NA 0.02 O.05 O.05 XXX 78586 26 A Aerosol lung image, single 0.40 3.67 NA 0.02 NA 0.08 XXX 78586 26 A Aerosol lung image, multiple 0.49 4.61 NA 0.03 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 4.61 NA 0.03 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 4.61 NA 0.03 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 0.15 0.12 0.02 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.00 XXX 78587 A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.00 XXX 78587 A Aerosol lung image 0.00 7.27 NA 0.00 NA 0.00 XXX 78587 A Aerosol lung image 0.00 0.12 0.12 0.01 NA 0.00 XXX 78581 TC A Aerosol lung image 0.40 3.67 NA 0.00 NA 0.00 XXX 78591 TC A Aerosol lung image 0.40 3.67 NA 0.00 NA 0.00 XXX 78591 TC A Aerosol lung image 1.09 0.40 3.67 NA 0.00 NA 0.00 XXX 78591 TC A Aerosol lung image 1.00 0.40 3.67 NA 0.00 NA 0.00 XXX 78591 TC A Aerosol lung image 1.00 0.40 0.12 0.12 0.12 A A A A A A A A A	Heart infarct image	(3D)	0.00	2.00	ζ Z	000	XXX	78585	Ţ	< ∢	Lung V/C maging	0.00	7.20	Z Z	000	XXX
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NA 0.00 XXX 78586 TC A Aerosol lung image, single 0.00 3.55 NA 0.00 0.29 0.028 XXX 78586 26 A Aerosol lung image, single 0.40 0.12 0.12 0.02 NA 0.00 XXX 78587 TC A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.02 XXX 78588 A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.03 XXX 78588 A Perfusion lung image, multiple 0.49 0.13 0.13 0.03 NA 0.00 XXX 78588 1C A Perfusion lung image, multiple 0.49 0.13 0.03 NA 0.00 XXX 78588 1C A Perfusion lung image, multiple 0.49 0.13 0.01 NA 0.02 XXX 78588 1C A Vent image, l breath, l proj 0.40 3.57 NA 0.00 NA	Gated heart, plana	. sinele	0.98	4.80	N.	0.05	XXX	78586		4	Aerosol lung image, single	0.40	3.67	NA	0.02	XXX
0.29 0.05 XXX 78886 26 A Aerosol lung image, single 0.40 0.12 0.12 0.02 NA 0.08 XXX 7887 A Aerosol lung image, multiple 0.49 4.61 NA 0.00 NA 0.00 XXX 78587 TC A Aerosol lung image, multiple 0.49 4.61 NA 0.00 NA 0.00 XXX 78588 A Perfusion lung image 1.09 7.28 NA 0.01 NA 0.02 XXX 78588 TC A Perfusion lung image 1.09 7.27 NA 0.07 NA 0.02 XXX 78588 1.6 A Perfusion lung image 1.09 7.27 NA 0.07 NA 0.02 XXX 78581 TA Vert image, I breath, I proj 0.40 3.51 NA 0.02 NA 0.03 XXX 78591 A Vent image, I breath, I proj 0.40 4.19 NA 0.04 NA 0.05	Gated heart, planar, single	r, single	0.00	4.51	N'A	00'0	XXX	78586	IC	¥	Aerosol lung image, single	00'0	3.55	NA	0.00	XXX
NA 0.08 XXX 78887 A Acrosol Lung image, multiple 0.49 4.61 NA 0.03 0.40 0.00 XXX 7887 2.6 A Acrosol Lung image, multiple 0.00 4.48 NA 0.00 0.40 0.07 XXX 7888 A Acrosol Lung image, multiple 0.00 4.48 NA 0.00 NA 0.03 XXX 7888 A Perfusion lung image 1.00 7.27 NA 0.00 0.16 0.02 XXX 7858 2.6 A Perfusion lung image 1.00 7.27 NA 0.00 NA 0.02 XXX 78591 A Vent image, 1 breath, 1 proj 0.40 3.67 NA 0.00 NA 0.00 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.40 3.67 NA 0.00 NA 0.01 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.40 3.67 NA 0.04 NA 0.05 X	Gated heart, planar, single	r, single	0.98	0.29	0.29	0.05	XXX	78586	56	4	Aerosol lung image, single	0.40	0.12	0.12	0.02	XXX
NA 0.00 XXX 78557 TC A Aerosol lang image, multiple 0.00 4.48 NA 0.00 0.46 0.07 XXXX 78587 2.6 A Perfusion lang image 1.09 1.33 0.13 0.01 0.00 NA 0.02 XXXX 78588 1.0 A Perfusion lang image 0.00 7.27 NA 0.00 NA 0.02 XXX 78588 2.6 A Perfusion lang image 1.09 0.31 0.31 0.07 NA 0.02 XXX 78591 A Vent image, I breath, I proj 0.40 3.57 NA 0.00 NA 0.03 XXX 78591 TC A Vent image, I breath, I proj 0.40 3.57 NA 0.00 NA 0.03 XXX 78591 TC A Vent image, I breath, I proj 0.40 3.57 NA 0.00 NA 0.01 XXX 78591 A Vent image, I breath, I proj 0.40 4.19 NA 0.04	Gated heart, multiple	, se	1.47	6.02	NA	80.0	XXX	78587		٧	Aerosol lung image, multiple	0.49	4.61	NA	0.03	XX
0.46 0.07 XXX 78857 26 A Aerosol lung image, multiple 0.49 0.13 0.13 0.03 NA 0.00 XXX 78588 A Perfusion lung image 1.09 7.58 NA 0.00 0.16 0.02 XXX 78588 26 A Perfusion lung image 1.09 7.27 NA 0.00 NA 0.02 XXX 78591 TC A Vent image, I breath, I proj 0.40 3.67 NA 0.02 0.10 0.01 XXX 78591 TC A Vent image, I breath, I proj 0.40 3.67 NA 0.00 NA 0.02 XXX 78591 26 A Vent image, I breath, I proj 0.40 3.57 NA 0.00 NA 0.03 XXX 78591 26 A Vent image, I breath, I proj 0.40 3.57 NA 0.00 NA 0.05 XXX 78591 26 A Vent image, I preath, I proj 0.40 4.19 NA 0.04	Gated beart, unultiple	ole	0.00	5.56	NA	00.0	XXX	78587	J.	٧	Aerosol lung image, multiple	0.00	4.48	NA	0.00	XXX
NA 0.03 XXX 7858 A Perfusion lung image 1.09 7.58 NA 0.07 0.40 XXX 78588 26 A Perfusion lung image 0.00 7.27 NA 0.00 0.10 XXX 78588 26 A Perfusion lung image 0.00 7.27 NA 0.00 NA 0.02 XXX 78591 A Venti image, 1 breath, 1 proj 0.40 3.67 NA 0.00 1.10 0.01 XXX 78591 A Venti image, 1 breath, 1 proj 0.40 3.67 NA 0.00 1.10 0.01 XXX 78591 A Venti image, 1 breath, 1 proj 0.40 3.67 NA 0.00 1.10 0.01 XXX 78591 A Venti image, 1 proj, gas 0.49 4.19 NA 0.04 1.10 XXX 78593 A Venti image, 1 proj, gas 0.49 4.19 NA 0.04 1.10 <	Gated heart, multiple	ple	1.47	0.46	0,46	0.07	XXX	78587	56	٧	Aerosol lung image, multiple	0.49	0.13	0.13	0.03	XX
NA 0.00 XXX 7858 TC A Perfusion lung image 0.00 7.27 NA 0.00	Heart wall motion add-on	add-on	0.50	0.56	NA A	0.03	XXX	78588		۷	Perfusion lung image	1.09	7.58	Ϋ́Z	0.07	XX
0.02 XXX 7858 26 A Perfusion lung image 1.09 0.31 0.31 0.37 0.00 XXX 78591 A Vent image, 1 breath, 1 proj 0.40 3.57 NA 0.00 0.01 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.40 3.55 NA 0.00 0.02 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.40 3.55 NA 0.00 0.03 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.04 XXX 78593 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.05 XXX 78593 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.06 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.07 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.08 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.09 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.00 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.01 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.01 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.01 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.01 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.02 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 0.02 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.12 0.02 0.03 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.12 0.12 0.02 0.04 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.12 0.12 0.12 0.12 0.05 A Vent image, 1 breath, 1 brea	Heart wall motion add-on	add-on	0.00	0.40	NA	0.00	XXX	78588	TC.	¥	Perfusion lung image	0.00	7.27	YZ.	0.00	XX
NA 0.02 XXX 78591 A Vent image, 1 breath, 1 proj 0.40 3.67 NA 0.02 NA 0.00 XXX 78591 26 A Vent image, 1 breath, 1 proj 0.00 3.55 NA 0.00 0.10 0.01 XXX 78591 26 A Vent image, 1 preath, 1 proj 0.40 0.12 0.02 NA 0.05 XXX 78593 A Vent image, 1 preath, 1 proj 0.49 4.19 NA 0.04 NA 0.05 XXX 78593 A Vent image, 1 preath, 1 proj 0.49 4.19 NA 0.04 NA 0.05 XXX 78593 A Vent image, 1 preath, 1 proj 0.49 4.19 NA 0.04 NA 0.05 XXX 78593 A Vent image, 1 preath, 1 proj 0.49 4.19 NA 0.04 NA 0.05 XXX 1 preath, 1 pre	Heart wall motion add-on	ndd-on	0.50	0,16	0.16	0.02	XXX	78588	56	¥	Perfusion lung image	1.09	0.31	0.31	0.07	XX
NA 0.00 XXX 78591 TC A Vent image, 1 breath, 1 proj 0.00 3.55 NA 0.00 0.10 0.01 XXX 78591 26 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 NA 0.05 XXX 78593 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 NA 0.05 XXX 78593 A Vent image, 1 proj, gas 0.49 4.19 NA 0.04 All Rights Properties Properties and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Reserved. All Rights Reserved. Properties and descriptions only are copyright 2009 American Medical Association. All Rights All Rights All Rights All Rights Reserved. Properties and descriptions only are copyright 2009 American Properties and Are not used for Medicare payment. All Rights	Heart function add-on	-00	0.30	0.49	Ν	0.02	XXX	18291		٧	Vent image, 1 breath, 1 proj	0.40	3.67	NA A	0.02	XXX
0.01 XXX 78591 26 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 NA 0.05 XXX 78593 A Vent image, 1 breath, 1 proj 0.40 0.12 0.12 0.02 A Vent image, 1 proj, gas 0.49 4.19 N 0.04 A I Project Sand descriptions only are copyright 2009 American Medical Association. All Rights Reserved. I values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the etitoryastic demonstration is not reflected in the files used for Medicare payment. The budget neutrality reduction from the etitoryastic demonstration is not reflected in the files used for Medicare payment. A Clobal Ionals for malfranctice R VI is may not sun due to rounding	Heart function add-on	q-on	0.00	0.40	NA	0.00	XXX	18591	JC	¥	Vent image, 1 breath, 1 proj	0.00	3.55	Y.	000	X
NA 0.05 XXX 78593 A Vent image, I proj. gas 0.49 4.19 NA 0.04 A Neat image I proj. gas 0.49 4.19 NA 0.04 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 1 I values are reflected for codes not payable by Medicare, please note that these values have been established as a coursey of the general public and are not used of Medicare appraerd. 1 The budget reutrality reduction from the chirogractic demonstration is not reflected in the files used for Medicare appraerd. 1 The budget reutrality reduction from the chirogractic demonstration is not reflected in the files used for Medicare payment. 2 The budget reutrality reduction from the chirogractic demonstration is not reflected in the files used for Medicare payment. 3 The budget reutrality reduction from the chirogractic demonstration is not reflected in the files used for Medicare payment. 4 Clobal totals for malmanties RVI is may not sun due to nonding	Heart function add-on	l-on	0.30	0.10	0.10	10.0	XXX	18891	56	∢	Vent image, I breath, I proj	0.40	0.12	0.12	0.02	XX
All Rights set bave been in the RVUs for CPT of files used for	Heart first pass, single	ngle	86.0	3.68	VV	0.05	XXX	78593		٧	Vent image, i proj, gas	0.49	4.19	NA	0.04	ž
es bave been in the RVUs for CPT cles used for	escriptions only ar	e copyright 200	P American Med	ical Associa	tion. All Ri	ghts			CPT	odes and o	escriptions only are copyright 2009.	American Med	lical Associa	ion. All Rig	hts	
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in the RVUs for CPT 3	urtesy to the gene	ral public and an	neare, prease no e not used for M	dicare payr	ent.	3			establis	ed as a co	urtesy to the general public and are	not used for M	edicare paym	ent.		
ed in the files used for	ality reduction fro	un the chiropract	ic demonstration	is not reflec	ted in the R	VUs for CPT			The bu	dget neutr	ality reduction from the chiropractic	demonstration	s not reflec	ted in the R	Us for CPT	
	Codes 98940, 98941, and 96942. In	e requirea realic	ton will only be	m nanana	me rites asc	ž			Medical	e navmen	i, and 20242. The required reducers	on will out y be	ובווברורת זה	race times discre	5	
	malmactice R VI Is	may not sum de	e to rounding						4 Globa	totals for	maloractice RVUs may not sum due	to rounding.				

If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Political Series Opinio Series No. 5 Series South Series Political S	į			Physician	Non- Facility	Facility	Mai		<u> </u>				Physi- clan	Non- Facility	Facility	Ma-	
XXX YARATHORN SALES A CYST AGAIL ACTIVATION OF STATE	Po		Description	Work RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3,4}	Global	HCPCS	Pow	Status	Description	RVUs.	RVUs ^{2,3}	RVUs ^{2,3}	RVUe ^{2,3,4}	Global
XXX XXX YXX XXX XXX <th>2</th> <th>4</th> <th>Vent image, 1 proj, gas</th> <th>0.00</th> <th>4.06</th> <th>NA</th> <th>0.00</th> <th>XXX</th> <th>78645</th> <th>56</th> <th>¥</th> <th>CSF shunt evaluation</th> <th>0.57</th> <th>0.15</th> <th>0.15</th> <th>0:04</th> <th>XXX</th>	2	4	Vent image, 1 proj, gas	0.00	4.06	NA	0.00	XXX	78645	56	¥	CSF shunt evaluation	0.57	0.15	0.15	0:04	XXX
XXX XXXX 78647 1C A Cerebrospital fluid stam 0.00 5.79 NA 0.00 XXX XXXX 78657 1 A Cerebrospital fluid stam 0.00 5.79 NA 0.00 XXX 78650 1 A CCSF leaking imaging 0.01 1.01 0.11 0.01 0.00 XXX 78660 15 A CCSF leaking imaging 0.01 1.01 0.11 0.01 XXX 78660 15 A Nuclear cann of tear flow 0.03 0.01 0.00 XXX 78600 15 A Nuclear cann of tear flow 0.03 0.01 0.00 0.00 XXX 78700 C Nuclear cann of tear flow 0.03 0.01 0.00 0.00 XXX 78700 C Nuclear cann of tear flow 0.03 0.04 0.00 0.00 XXX 78700 A Nuclear cann out of tear flow 0.03 0.01 0.00	76	¥	Vent image, I proj. gas	0.49	0.14	0.14	0.03	XXX	78647		ĸ	Cerebrospinal fluid scan	0.90	16.3	Z Y	0.07	XXX
XXX Yes 78647 26 A Certebrogath Indi stam 0.60 7.19 0.11 0.00 XXX XXXX 78650 1C A CSF leakage imaging 0.60 7.19 NA 0.00 XXX 78660 2 A CSF leakage imaging 0.61 0.16 0.16 0.16 0.00 XXX 78660 2 A Nuclear cann of fear flow 0.03 3.71 NA 0.00 XXX 78660 1C A Nuclear cann of fear flow 0.03 0.07 0.01 0.00 XXX 78700 1C A Nuclear cann of fear flow 0.05 0.07 0.00 0.00 XXX 78700 1C A Nuclear cann of fear flow 0.04 4.5 0.04 0.03 XXX 78700 1C A Nuclear cann of fear flow 0.04 4.7 0.00 XXX 78700 1C A Nuclear cann of fear flow 0.00		4	Vent image, mult proj, gas	0.53	4.45	ďΖ	0.02	XXX	78647	C	٧	Cerebrospinal fluid scan	0.00	5.79	K Z	0.00	XXX
XXXX 7855 A CSF leakage imaging 061 719 NA 000 XXXX 7859 2 A CSF leakage imaging 061 101 0.16 0.05 XXXX 7856 1 A Nuclear cann of tear flow 0.33 184 NA 0.00 XXXX 7869 1 A Nuclear cann of tear flow 0.03 0.07 NA 0.00 XXXX 7869 2 A Nuclear cann of tear flow 0.03 0.00 0	2	∢	Vent image, mult proj, gas	0.00	4.31	Ϋ́	0.00	XXX	78647	56	¥	Cerebrospinal fluid scan	06.0	0.11	0.11	90.0	XXX
XXX Yes TC A CSF leakage imaging 0.06 119 NA 0.00 XXX 78660 26 A CSF leakage imaging 0.01 1.01 0.01 0.00	56	٧	Vent image, mult proj. gas	0.53	0.13	0.13	0.02	XXX	78650		4	CSF leakage imaging	0.61	7.34	N'A	0.04	XXX
XXXX 78560 26 A CRF Backgo imaging 0.61 0.16 0.04 XXXX 78600 1C A Nuclear cann of tear flow 0.35 3.64 NA 0.00 XXXX 78600 1C C Nuclear cann of tear flow 0.03 1.77 0.17 0.10 XXXX 78690 26 A Nuclear cann of tear flow 0.03 0.00 0.00 XXXX 78690 1C C Nuclear cann of tear flow 0.03 0.00 0.00 0.00 XXXX 78700 2C Nuclear cann of tear flow 0.04 0.05 0.00 0.00 XXXX 78701 1C A Kidney imaging morphol 0.45 0.13 0.13 0.03 XXXX 78701 1C A Kidney imaging morphol 0.04 4.70 NA 0.00 XXXX 78701 1C A Kidney imaging with flow 0.04 4.44 NA 0.00		٧	Lung differential function	1.27	7.70	N	0.07	XXX	78650	7	Y	CSF leakage imaging	0.00	7.19	ΝA	0.00	XXX
XXXX 78660 1C Nuclear exam of fear flow 0.53 384 NA 0.00 XXXX 78690 1C Nuclear exam of fear flow 0.03 167 0.17 0.01 XXXX 78690 1C C Nuclear exam of fear flow 0.03 0.07 0.07 0.00 XXXX 78699 1C C Nuclear exam of fear flow 0.03 0.07 0.00 0.00 XXXX 78699 1C C Nucrous system unclear exam 0.00	2	٧	Lung differential function	0.00	7.35	Ϋ́Z	0.00	XXX	78650	56	٧	CSF leakage imaging	19'0	0.16	0.16	0.04	XXX
XXX XXX 78660 1C A Nuclear cann of fear flow 010 3.67 NA 0.00 XXXX 78699 2.6 C Nuclear cann of fear flow 0.30 0.07 0.07 0.00 NA 0.00 XXXX 78699 1.6 C Nervous system unclear exam 0.00	56	4	Lung differential function	1.27	0.35	0.35	90:0	XXX	18660		Ą	Nuclear exam of tear flow	0.53	3.84	NA	0.02	XXX
XXX 78660 26 A Nuclear cann of that flow 613 0.17 6.09 XXX XXX 78699 1.C C Nuclear cann of cannot on 0.00 0.00 NA 0.00 XXX 78699 1.C C Nuclear, system nuclear cannot 0.00 0.00 NA 0.00 XXX 78700 2.C Nervous system nuclear cannot 0.00 0.00 NA 0.00 XXX 78700 1.C A Kidney imaging, morphol 0.04 0.45 0.13 0.13 0.13 0.00		U	Respiratory nuclear exam	00.00	000	Ϋ́Z	0.00	XXX	78660	17	V	Nuclear exam of tear flow	0.00	3.67	NA	0.00	XXX
XXX 78699 C Nervous system nuclear exam 0.00 0.00 NA 0.00 XXX 78699 1C C Nervous system nuclear exam 0.00 0.00 0.00 0.00 0.00 0.00 XXX 78700 1 A Kidney imaging morphol 0.45 0.13 NA 0.00 XXX 78701 1 A Kidney imaging morphol 0.45 0.13 0.13 0.03 XXX 78701 1 A Kidney imaging morphol 0.45 0.13 0.14 0.13 0.03 XXX 78701 1 A Kidney imaging with flow 0.44 0.14 0.14 0.03 XXX 78701 1 A Kidney imaging with flow 0.45 1.4 NA 0.00 XXX 78702 A A Kidney imaging with flow 0.44 NA 0.00 XXX 78702 A A Kidney imaging with flow 0.44 NA	Ţ		Respiratory nuclear exam	0.00	0.00	Ž	0.00	XXX	78660	56	*	Nuclear exam of tear flow	0.53	0.17	0.17	0.01	XXX
XXX XXX 78899 TC Nervous system nuclear exam 0.00	2		Respiratory nuclear exam	0.00	0.00	00.00	000	XXX	78699		Ç	Nervous system nuclear exam	0.00	0.00	N.A	00.0	XXX
XXX XXX 78699 26 C Nörrous system nuclear exam 0.00 0.00 0.00 0.00 XXX 78700 1 A Kidney imaging, unorphol 0.45 3.70 NA 0.00 XXX 78701 1 A Kidney imaging, unorphol 0.45 4.70 NA 0.00 XXX 78701 2 A Kidney imaging with flow 0.49 4.70 NA 0.00 XXX 78701 2 A Kidney imaging with flow 0.49 4.70 NA 0.00 XXX 78701 2 A Kidney imaging with flow 0.49 4.70 NA 0.00 XXX 78707 1 A Kidney funct image with flow 0.49 4.70 NA 0.00 XXX 78708 1 A Kidney funct image with flow 0.49 4.70 NA 0.00 XXX 78709 1 A Kidney funct image with flow 0.49 4.70 NA 0.00 XXX 78709 1 A Kidney fun		×	Brain image < 4 views	0.44	3.94	A.	0.02	XXX	18699	IC	ڼ	Nervous system nuclear exam	0.00	0.00	NA	000	XXX
XXX 78700 A Kidley imaging, morphol 0.45 3.70 NA 0.03 XXX 78700 1C A Kidley imaging, morphol 0.45 0.13 0.13 0.03 XXX 78701 1C A Kidley imaging, with flow 0.49 4.70 NA 0.03 XXX 78701 2.6 A Kidley imaging, with flow 0.49 0.14 0.14 0.03 XXX 78701 1.C A Kidley imaging, with flow 0.49 0.14 0.14 0.03 XXX 78707 1.C A Kidley imaging, with flow 0.49 0.14 0.14 0.03 XXX 78707 2.6 A Kidley imaging, with flow 0.40 0.26 0.26 0.06 XXX 78708 1.C A Kidley imaging, with flow 0.00 2.23 NA 0.00 XXX 78709 1.C A Kidley imaging, with flow 0.00 2.26 0.26	TC	<	Brain image < 4 views	0.00	3.81	Ϋ́	00:0	XXX	66981	56	Ų	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX
XXX 78700 TC A Kiddey imaging, morphol 0.45 0.13 0.13 0.03 XXX 78701 A Kiddey imaging, morphol 0.44 4.70 NA 0.03 XXX 78701 TC A Kiddey imaging with flow 0.49 4.70 NA 0.03 XXX 78707 TC A Kiddey imaging with flow 0.49 0.44 0.14 0.03 XXX 78707 TC A Kiddey imaging with flow 0.49 0.44 0.14 0.03 XXX 78707 TC A Kiddey imaging with flow 0.49 0.44 NA 0.06 XXX 78708 A A Kiddey imaging with flow 0.44 NA 0.08 XXX 78708 A A Kiddey imaging with flow 0.44 NA 0.08 XXX 78709 A Kiddey imaging with flow 0.49 0.44 NA 0.08 XXX 78710	26	< <	Brain image < 4 views	0.44	0.13	0.13	0.02	XXX	78700		٧	Kidney imaging, morphol	0.45	3.70	N.A.	0.03	XXX
XXX 78700 26 A Kiditey imaging, morphol 0.45 0.13 0.13 0.03 XXX 78701 C A Kiditey imaging, with flow 0.04 4.70 NA 0.00 XXX 78701 C A Kiditey imaging with flow 0.04 0.14 0.14 0.03 XXX 78707 1 A K flow/funct image w/o drug 0.04 4.44 NA 0.00 XXX 78707 1 A K flow/funct image w/o drug 0.05 0.25 0.05 0.06 0	ì	. 4	Brain image w/flow < 4 views	0.51	4.62	×	0.03	XXX	78700	IC	Α.	Kidney imaging, morphol	000	3.57	N.	000	XXX
XXX 78701 A Kidney imaging with flow 0.49 4.70 NA 0.03 XXX 78701 TC A Kidney imaging with flow 0.49 4.70 NA 0.03 XXX 78707 TC A Kidney imaging with flow 0.96 4.70 NA 0.00 XXX 78707 TC A Kidow/funct image w/o drug 0.96 4.70 NA 0.00 XXX 78708 TC A Kidow/funct image w/drug 0.00 4.44 NA 0.00 XXX 78708 TC A Kidow/funct image w/drug 0.00 2.35 NA 0.00 XXX 78709 A Kidow/funct image, multiple 0.00 4.20 NA 0.00 XXX 78709 A Kidow/funct image, multiple 0.01 0.35 0.39 0.03 0.03 XXX 78710 A Kidow/funct image, m/drug 0.00 4.20 NA 0.00	Ţ		Brain image w/flow < 4 views	0.00	4.48	Z	0.00	XXX	78700	70	A	Kidney imaging, morphol	0.45	0.13	0.13	0.03	XXX
XXX 78701 TC A Kidney imaging with flow 0.06 4.56 NA 0.09 XXX 78707 A K Ghey funct image w/o drug 0.96 0.14 0.04 0.05 XXX 78707 TC A K Ghey/funct image w/o drug 0.96 0.26 0.26 0.06 XXX 78708 A K Gow/funct image w/ord 0.06 0.44 NA 0.00 XXX 78708 A K Gow/funct image w/crug 0.05 0.25 0.05 0.08 XXX 78708 A K Gow/funct image w/crug 1.21 2.87 NA 0.00 XXX 78709 A K Gow/funct image w/crug 1.21 0.33 0.33 0.03 XXX 78709 A K Gow/funct image w/crug 1.21 0.35 NA 0.00 XXX 78710 A K Gow/funct image w/crug 1.21 0.39 0.39 0.39 0.39 0.39 0.39 0.39 0.39	2,9		Brain image w/flow < 4 views	0.51	0.14	0.14	0.03	XXX	78701		¥	Kidney imaging with flow	0.49	4.70	X	0.03	XXX
XXX 78701 26 A Kidney imaging with flow 0.49 0.14 0.14 0.05 XXX XXX 78707 A K flow/funct image w/o drug 0.05 4.70 NA 0.06 XXX 78707 1.C A K flow/funct image w/o drug 0.05 4.70 NA 0.06 XXX 78708 A K flow/funct image w/ording 0.12 1.287 NA 0.06 XXX 78708 1.C A K flow/funct image w/ording 0.05 4.70 NA 0.06 XXX 78709 1.C A K flow/funct image w/ording 0.07 2.87 NA 0.09 XXX 78709 1.C A K flow/funct image w/ording 0.07 2.87 NA 0.09 XXX 78710 1.C A K flow/funct image w/ording 0.05 4.20 NA 0.09 XXX 78710 1.C A K flow/funct image w/ording 0.05 4.20 <td< td=""><td>ì</td><td>: <</td><td>Brain image 4+ views</td><td>0.53</td><td>4.20</td><td>Ą</td><td>0.04</td><td>XXX</td><td>10287</td><td>IC</td><td><</td><th>Kidney imaging with flow</th><td>0.00</td><td>4.56</td><td>NA</td><td>000</td><td>XXX</td></td<>	ì	: <	Brain image 4+ views	0.53	4.20	Ą	0.04	XXX	10287	IC	<	Kidney imaging with flow	0.00	4.56	NA	000	XXX
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XXX 78707 TC A K flow/funct image w/o drug 0.00 4.44 NA 0.00 XXX XXX 78708 A A K flow/funct image w/drug 1.21 0.25 0.26 0.06 XXX 78708 TC A K flow/funct image w/drug 1.21 0.33 0.33 0.08 XXX 78709 TC A K flow/funct image w/drug 1.21 0.33 0.33 0.08 XXX 78709 TC A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 TC A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 TC A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 TC A K flow/funct image, multiple 1.41 0.39	36	. 4	Brain image 4+ views	0.53	0.15	0.15	0.0	XXX	78707		<	K flow/funct image w/o drug	96.0	4.70	N.	90.0	XXX
XXX 78707 26 A K flow/funct image w/o drug 0.96 0.26 0.26 0.06 XXX 78708 A K flow/funct image w/drug 1.21 2.87 NA 0.08 XXX 78708 26 A K flow/funct image w/drug 1.21 0.33 0.33 0.08 XXX 78709 1 A K flow/funct image, multiple 1.41 7.67 NA 0.09 XXX 78709 2.6 A K flow/funct image, multiple 1.41 0.39 0.08 XXX 78710 1 A K flow/funct image, multiple 0.06 4.20 NA 0.09 XXX 78710 1 A K flow/funct image, multiple 0.06 4.20 NA 0.00 XXX 78710 1 A K flow/funct image, multiple 0.06 4.20 NA 0.00 XXX 78710 1 A K flow/funct image, multiple 0.06 4.20 NA 0.00<	ì	٠.	Brain image w/flow 4 + views	0.64	7.69	N.	0.03	XXX	78707	C	¥	K flow/funct image w/o drug	00.0	4.4	NA	0.00	XXX
XXX 78708 A K flow/funct image w/drug 1.21 2.87 NA 0.08 XXX 78708 TC A K flow/funct image w/drug 0.00 2.53 NA 0.00 XXX 78709 A K flow/funct image, multiple 0.00 7.28 NA 0.09 XXX 78709 1C A K flow/funct image, multiple 0.00 7.28 NA 0.09 XXX 78709 1C A K flow/funct image, multiple 0.00 7.28 NA 0.09 XXX 78710 1C A K flow/funct image, multiple 0.00 7.28 NA 0.09 XXX 78710 1C A K flow/funct image, multiple 0.06 4.20 0.39 0.03 XXX 78710 1C A K flow/funct imaging (3D) 0.06 1.8 NA 0.00 XXX 78725 1C A K flower function study 0.06 2.08 NA 0.00	$\mathbf{I}^{\mathbf{C}}$	< <	Brain image w/flow 4 + views	000	7.50	NA	0.00	XXX	78707	56	4	K flow/funct image w/o drug	96.0	0.26	0.26	90:0	XXX
XXX 78708 TC A K flow/funct image w/drug 0.00 2.53 NA 0.00 XXX 78708 26 A K flow/funct image w/drug 1.21 0.33 0.33 0.08 XXX 78709 TC A K flow/funct image, multiple 0.00 7.28 NA 0.00 XXX 78710 TC A K flow/funct image, multiple 0.00 7.28 NA 0.00 XXX 78710 TC A K flow-funct image, multiple 0.06 4.05 NA 0.00 XXX 78710 TC A K flow-function study 0.06 4.05 NA 0.00 XXX 78725 A K kldroy function study 0.38 0.18 NA 0.00 XXX 78730 A K kldroy function study 0.38 0.12 0.03 XXX 78730 A K kldroy function study 0.38 0.12 0.12 0.00 XXX	26	<	Brain image w/flow 4 + views	0.64	0.19	0.19	0.03	XXX	78708		A	K. flow/funct image w/drug	1,21	2.87	NA	80:0	XXX
XXX 78708 26 A K flow/funct image w/drug 121 0.33 0.33 0.08 XXX 78709 T A K flow/funct image, multiple 1.41 7.67 NA 0.00 XXX 78709 1C A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 A K flow/funct image, multiple 1.41 0.39 0.39 0.08 XXX 78710 A K flowey function study 0.66 4.20 NA 0.03 XXX 78725 A K flowey function study 0.38 2.18 NA 0.00 XXX 78730 A K flowey function study 0.38 0.12 0.01 0.00 XXX 78730 A K flowey function study 0.15 1.51 NA 0.00 XXX 78740 A		Ą	Brain imaging (3D)	1.23	7.38	NA	0.07	XXX	78708	1C	٧	K flow/funct image w/drug	00.0	2.53	NA	0.00	XXX
XXX 78709 A K flow/funct image, multiple 141 767 NA 0.09 XXX 78709 1C A K flow/funct image, multiple 1.41 7.67 NA 0.09 XXX 78710 1C A K flow/funct image, multiple 0.66 4.20 NA 0.00 XXX 78710 1C A K flower imaging (3D) 0.06 4.20 NA 0.00 XXX 78712 A K flower imaging (3D) 0.06 0.15 0.15 0.00 XXX 78725 A K flower imaging (3D) 0.06 0.15 0.15 0.00 XXX 78725 A K flower imaging (3D) 0.06 0.15 0.01 0.00 XXX 78730 A K flower imaging (3D) 0.06 0.15 0.01 0.00 XXX 78730 A Urinary bladder retention 0.15 0.12 0.01 XXX 78740 A Urinary bladder retention<	10	¥	Brain imaging (3D)	0.00	7.07	NA	0.00	XXX	78708	56	K	K flow/funct image w/drug	1.21	0.33	0.33	80.0	XXX
XXX 78709 TC A K flow/funct image, multiple 0.00 7.28 NA 0.00 XXX 78709 2.6 A K flow/funct image, multiple 0.00 4.20 0.39 0.03 XXX 78710 TC A Kidney imaging (31) 0.06 4.05 NA 0.00 XXX 78715 A Kidney imaging (31) 0.06 0.15 0.15 0.03 0.03 XXX 78725 A Kidney imaging (31) 0.06 0.16 0.15 0.01 XXX 78725 A Kidney imacino study 0.38 0.12 0.15 0.00 XXX 78730 A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78730 TC A Urinary bladder retention 0.15 0.05 0.04 4.05 NA 0.00 XXX 78740 TC A Urinary bladder retention 0.15 4.98 NA 0.00 <td>56</td> <td>V</td> <td>Brain imaging (3D)</td> <td>1.23</td> <td>0.31</td> <td>0.31</td> <td>0.07</td> <td>XXX</td> <td>78709</td> <td></td> <td>٧</td> <th>K flow/funct image, multiple</th> <td>141</td> <td>1.67</td> <td>Y.</td> <td>60:0</td> <td>ž</td>	56	V	Brain imaging (3D)	1.23	0.31	0.31	0.07	XXX	78709		٧	K flow/funct image, multiple	141	1.67	Y.	60:0	ž
XXX 78799 26 A K flow/funct image, multiple 141 0.39 0.39 0.08 XXX 78710 TC A Kidney imaging (3D) 0.66 4.20 NA 0.00 XXX 78710 26 A Kidney imaging (3D) 0.66 0.15 0.15 0.03 XXX 78725 A Kidney function study 0.09 2.06 NA 0.00 XXX 78730 TC A Kidney function study 0.09 2.06 NA 0.00 XXX 78730 TC A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78730 Z6 A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 0.15 0.12 0.01 0.04 NA			Brain imaging (PET)	0.00	0.00	NA	0.00	XXX	78709	IC	∢	K flow/funct image, multiple	0.00	7.28	Y.	0.00	XX
XXX 78710 A Kidney imaging (31) 0.66 4.20 NA 0.03 XXX 78710 TC A Kidney imaging (31) 0.66 4.20 NA 0.09 XXX 78725 A Kidney function study 0.38 2.18 NA 0.03 XXX 78725 TC A Kidney function study 0.38 0.12 0.00 XXX 78730 A Kidney function study 0.00 2.06 NA 0.00 XXX 78730 A Urinary bladder retention 0.15 1.51 NA 0.01 XXX 78740 A Urinary bladder retention 0.15 0.15 0.05 0.01 XXX 78740 A Urinary bladder retention 0.15 0.15 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 0.95 0.01 NA 0.04 XXX 78740 A Urinary bladder retention <t< td=""><td>TC</td><td></td><td>Brain imaging (PET)</td><td>0.00</td><td>0.00</td><td>Ϋ́</td><td>0.00</td><td>XXX</td><td>78709</td><td>70</td><td>V</td><th>K flow/funct image, multiple</th><td>1.4</td><td>0.39</td><td>0.39</td><td>80.0</td><td>X</td></t<>	TC		Brain imaging (PET)	0.00	0.00	Ϋ́	0.00	XXX	78709	70	V	K flow/funct image, multiple	1.4	0.39	0.39	80.0	X
XXX 78710 TC A Kidney imaging (31) 0.00 4.05 NA 0.00 XXX 78725 A Kidney imaging (31) 0.06 0.15 0.15 0.03 XXX 78725 A Kidney function study 0.08 2.06 NA 0.00 XXX 78725 A Kidney function study 0.38 0.12 0.12 0.12 0.00 XXX 78730 A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78730 A Urinary bladder retention 0.15 4.98 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 4.98 NA 0.00 XXX 78740 TC A Urieteral reflux study 0.57 4.98 NA 0.00 XXX 78740 TC A Urieteral reflux study 0.57 0.18 0.00 XXX 78761 TC A U	56	¥	Brain imaging (PET)	1.50	0.39	0.39	60.0	XXX	78710		4	Kidney imaging (3D)	99.0	4.20	Š	0.03	XX
XXX 78710 26 A Kidney imaging (3D) 0.66 0.15 0.15 0.03 XXX 78725 A Kidney function study 0.38 2.18 NA 0.00 XXX 78725 1C A Kidney function study 0.38 0.12 0.12 0.00 XXX 78730 1C A Urinary bladder retention 0.15 1.51 NA 0.00 XXX 78730 26 A Urinary bladder retention 0.15 1.46 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 0.14 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 0.15 0.05 0.01 XXX 78740 A Urinary bladder retention 0.15 0.16 NA 0.00 XXX 78761 A Urinary bladder retention 0.15 0.18 NA 0.00 XXX 78761 A Ureteral reflux study 0.00 4.24 NA 0.00 XXX		Z	Brain imaging (PET)	1.50	0.55	Y Z	80.0	xxx	78710	JC	٧	Kidney imaging (3D)	0.00	4.05	NA V	0.00	X
XXX 78725 T.C. A. Kidney function study 0.38 2.18 NA 0.02 XXX 78725 T.C. A. Kidney function study 0.00 2.06 NA 0.00 XXX 78730 T.A. Virinary bladder retention 0.15 1.51 NA 0.01 XXX 78730 T.C. A. Urinary bladder retention 0.15 1.51 NA 0.01 XXX 78740 T.C. A. Urinary bladder retention 0.15 0.05 0.05 0.01 XXX 78740 A. Urinary bladder retention 0.15 0.05 0.05 0.01 XXX 78740 A. Urinary bladder retention 0.15 4.98 NA 0.00 XXX 78740 A. Urinary bladder retention 0.15 4.98 NA 0.00 XXX 78761 A. Uriterial reflux study 0.07 4.89 NA 0.00 XXX 78761 A. Uriterial reflux study 0.07 4.44 NA 0.00 XXX 78761 T.C. A. Testicul	56	z	Brain imaging (PET)	1.50	0.55	0.55	80.0	XXX	78710	56	¥	Kidney imaging (3D)	99.0	0.15	0.15	0.03	X
XXX 78725 To A Kidney function study 0.00 2.06 NA 0.00 XXX 78730 A Vintary bladder retention 0.15 1.51 NA 0.01 XXX 78730 TC A Urinary bladder retention 0.00 1.46 NA 0.00 XXX 78740 A Urinary bladder retention 0.01 1.46 NA 0.00 XXX 78740 A Urinary bladder retention 0.15 4.98 NA 0.00 XXX 78740 A Urieteral reflux study 0.07 4.80 NA 0.00 XXX 78761 TC A Urieteral reflux study 0.07 4.44 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.01 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00		<	Brain flow imaging only	0.30	3.77	Ν	10.0	XXX	78725		٧	Kídney function study	0.38	2.18	NA V	0.02	X
XXX 78725 26 A Kidney function study 0.18 0.12 0.12 0.02 XXX 78730 TC A Urinary bladder retention 0.16 1.51 NA 0.01 XXX 78730 TC A Urinary bladder retention 0.15 0.05 0.05 0.01 XXX 78740 TC A Urinary bladder retention 0.15 0.05 0.05 0.01 XXX 78740 TC A Ureteral reflux study 0.07 4.98 NA 0.04 XXX 78761 TC A Ureteral reflux study 0.07 4.44 NA 0.00 XXX 78761 TC A Ureteral reflux study 0.07 4.44 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.01 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/flow <t< td=""><td>10</td><td>٧</td><td>Brain flow imaging only</td><td>0.00</td><td>3.68</td><td>NA</td><td>0.00</td><td>XXX</td><td>78725</td><td>21</td><td>∢ '</td><th>Kidney function study</th><td>0.00</td><td>5.06</td><td>NA.</td><td>0.00</td><td>X</td></t<>	10	٧	Brain flow imaging only	0.00	3.68	NA	0.00	XXX	78725	21	∢ '	Kidney function study	0.00	5.06	NA.	0.00	X
XXX 78730 A Urinary bladder retention 0.15 1.51 NA 0.01 XXX 78730 TC A Urinary bladder retention 0.00 1.46 NA 0.00 XXX 78740 TC A Ureteral reflux study 0.57 4.98 NA 0.04 XXX 78740 TC A Ureteral reflux study 0.00 4.80 NA 0.04 XXX 78761 A Testicular imaging w/flow 0.71 4.44 NA 0.05 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 1 Crocks and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. 1 value as reflected for codes not payable by Medicare, please note t	56	٧	Brain flow imaging only	0.30	0.08	0.08	0.01	XXX	78725	56	V	Kidney function study	0.38	0.12	0.12	0.02	X
XXX		∢	Cerebrospinal fluid scan	99.0	7.59	ΥZ	0.04	XXX	78730		K	Urinary bladder retention	0.15	1.51	¥Z.	0.01	777
XXX	12	V	Cerebrospinal fluid scan	0.00	7.40	Y V	0.00	XXX	78730	Ω	<	Urinary bladder retention	0.00	1.46	NA V	0.00	ZZZ
XXX 78740 A Ureteral reflux study 0.57 4.98 NA 0.04 XXX 78740 TC A Ureteral reflux study 0.07 4.80 NA 0.00 XXX 78761 A Testicular imaging w/flow 0.71 4.44 NA 0.03 XXX 78761 A Testicular imaging w/flow 0.01 4.22 NA 0.05 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 A Testicular imaging w/flow 0.00 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 AXX Reserved. 2 1 4.44 NA 0.05 Reserved. 2 1 4.94 NA 0.00 Reserved. 2 1 4.94 NA 0.00 Reserved. 2 2 </td <td>56</td> <td>4</td> <td>Cerebrospinal fluid scan</td> <td>89.0</td> <td>0.19</td> <td>0.19</td> <td>0.04</td> <td>XXX</td> <td>78730</td> <td>56</td> <td>≺</td> <th>Urinary bladder retention</th> <td>0.15</td> <td>0.05</td> <td>0.05</td> <td>10.0</td> <td>222</td>	56	4	Cerebrospinal fluid scan	89.0	0.19	0.19	0.04	XXX	78730	56	≺	Urinary bladder retention	0.15	0.05	0.05	10.0	222
XXX 78740 TC A Uneteral reflux study 0.00 4.80 NA 0.00 XXX 78761 A Testicular imaging w/Row 0.71 4.44 NA 0.03 XXX 78761 T A Testicular imaging w/Row 0.71 4.44 NA 0.05 XXX 78761 TC A Testicular imaging w/Row 0.00 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/Row 0.00 4.22 NA 0.00 XXX 78761 TC A Testicular imaging w/Row 0.00 4.22 NA 0.00 COTT QC A Testicular imaging w/Row 0.00 4.22 NA 0.00 ROSE CC A Testicular imaging w/Row 0.00 4.22 NA 0.00 ROSE CC CC A Testicular imaging w/Row 0.00 4.22 NA 0.00 ROSE C		¥	CSF ventriculography	0.61	7.61	۷ Z	0.03	XXX	78740		<	Ureteral reflux study	0.57	4.98	NA	0.04	XX
XXX 78940 26 A Unetent reflux study 0.57 0.18 0.18 0.03 XXX 78761 A Testicular imaging w/flow 0.71 4.44 NA 0.05 XXX 78761 TC A Testicular imaging w/flow 0.71 4.44 NA 0.05 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved and descriptions only are copyright 2009 American Medical Association. All Rights Reserved as a country to only a decical control of the	10	¥	CSF ventriculography	0.00	7.42	ΥZ	00.0	XXX	78740	10	<	Ureteral reflux study	0.00	4.80	N.	0.00	XX
XXX 78761 A Testicular imaging w/flow 0.71 4.44 NA 0.05 XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been established as a counceys to the general public and are not used for Medicara payment. The budget neutrality reduction from the chriopractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Alcharl Insist for maltractice RVIs for connenting of the prometries of the pr	56	¥	CSF ventriculography	19'0	0.19	0.19	0.03	XXX	78740	56	٧	Ureteral reflux study	0.57	81.0	0.18	0.03	XXX
XXX 78761 TC A Testicular imaging w/flow 0.00 4.22 NA 0.00 LOPT codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been established as a councesty to the general public and are not used for Medicare appyment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. Actional Instable Are Insta		V	CSF shunt evaluation	0.57	7.28	NA	0.04	XXX	19287		K	Testicular imaging w/flow	0.71	4.44	NA	90'0	XXX
- In 00 024	$\mathfrak{I}^{\mathcal{C}}$		CSF shunt evaluation	0.00	7.13	Ϋ́	0.00	XXX	19787	ည	<	Testicular imaging w/flow	0.00	4.22	NA	0.00	XX
	6	codes and	1 descriptions only are copyright 2009	American Me	dical Associ	ation. All Ri	ghts			CPT	odes and	lescriptions only are copyright 2009 An	merican Med	ical Associat	on. All Rig	ıts	
on Say	eser	ved.		•	•					Reserve	Ę.			•			
	ž .	alues are re	effected for codes not payable by Medi.	are, piease no	ite that these	values bave	peen			II valu	es are ref	ected for codes not payable by Medicar	re, please not	e that these v	anies nave b	een	
0.24	Stab	lished as a	courtesy to the general public and are	not used for M	edicare pay	ment.	THE CASE OF			3 The L	ned as a c	ourtesy to the general public and are not	t used for Me	dicare paym	of.	Tago	
	1 E	pudget ner	utrality reduction from the chaopracus	demonstration	n tS not reas reflected in	the files use	VUS JOU OF A			rodes 93	10gei neui 2040, 989	fallty rediction now me currynactic or 41 and 08942. The required reduction	emonstrativu will only be	IS IN TRUCK.	ed in the r v	US tur C.r.ı for	
	i de	or torred i	1941, dild 20774. Tac tequades recovery	III Will vally es	Tementer		à			Medicar	re bavmen	Tis mile 20,7%, that requires recession.	with your over	· ··· nama	To the second		
	j [sol totals fr	cut. Ar malmascrice R VI is may not sum due	to rounding						Globa	totals for	malwactice RVUs may not sum due to	rounding.				

CPT ^{1,3} /			cian Work	Facility PE	Facility PE	Mat- Practice		CPT ^{4,3} f				clan Work	Non- Facility PE	Facility PE	Mal- Practice	
ຶ້	ű		RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2.3,4}	Global	HCPCS	Mod	Status	Description	RVUs.	RVUs ^{2, 3}	RVUs ^{2,3}	RVUs ^{2.3,4}	Global
18/61 20		l esticular imaging w/flow	0.71	0.22	77.0	0.05	XXX	78815	2	ပ .	Pet image w/ot, skull-thigh	0.00	9.0	S. S.	0.00	XXX
	ن	Gentournary nuclear exam	0.00	20:0	Y.	0.00	xxx	78815	56	₹	Pet mage w/ct, skull-thigh	2.44	0.68	0.68	0.17	XX
		Genitourinary nuclear exam	0.00	0.00	Ϋ́	0.00	XXX	78816		ပ	Pet image w/ct, full body	0.00	0.00	¥.	0.00	XX
78799 26		Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX	78816	C	U	Pet image w/ct, full body	0.00	0.00	Ϋ́	0.00	XX
		Tumor imaging, limited area	99.0	3.99	Ν	0.04	XXX	78816	56	4	Pet image w/ct, full body	2.50	89.0	89.0	0.17	XXX
•		Tumor imaging, limited area	0.00	3.78	NA	0.00	XXX	48668		ပ	Nuclear diagnostic exam	0.00	0.00	ΥN	0.00	XX
78800 26	5 A	Tumor imaging, limited area	99.0	0.20	0.20	0.04	XXX	78999	TC	၁	Nuclear diagnostic exam	0.00	0.00	ΥX	0.00	XXX
78801	٧	Tumor imaging, mult areas	0.79	5.31	Ν	0.05	XXX	48999	56	ပ	Nuclear diagnostic exam	0.00	0.00	0.00	00.0	XXX
78801 TC	A	Tumor imaging, mult areas	000	5.08	NA	0.00	XXX	79005		K	Nuclear rx, oral admin	1.80	1.61	ΝA	0.10	XXX
		Tumor imaging, mult areas	0.79	0.23	0.23	0.05	xxx	79005	TC	٧	Nuclear 1x, oral admin	0.00	1.08	NA	0.01	XXX
		Tumor imaging, whole body	0.86	6.94	N.	0.00	XXX	79005	76	٧	Nuclear rx, oral admin	1.80	0.53	0.53	60.0	XXX
78802 TC		Tumor imaging, whole body	0.00	6.71	Ν	0.00	XXX	19101		¥	Nuclear rx, iv admin	1.96	1.84	NA	0.10	XXX
		Tumor imaging, whole body	0.86	0.23	0.23	0.05	XXX	19101	IC	٧	Nuclear rx, iv admin	0.00	1.13	N.	0.01	XXX
78803	∢	Turnor imaging (3D)	1.09	7.20	ΝĄ	0.07	XXX	79101	76	¥	Nuclear rx, iv admin	1.96	0.72	0.72	60.0	XXX
78803 TC		Turnor imaging (3D)	0.00	6.92	NA	0.00	XXX	79200		4	Nuclear rx, intracay admin	1.99	2.07	NA	0.14	XXX
		Tumor imaging (3D)	1.09	0.27	0.27	90.0	XXX	79200	TC	٧	Nuclear rx, intracay admin	0.00	1.45	¥	0.01	XXX
		Tumor imaging, whole body	1.07	12.81	N.	0.07	XXX	79200	56	4	Nuclear rx, intracay admin	1.99	0.62	0.62	0.14	XXX
78804 TC		Tumor imaging, whole body	0.00	12.52	AN	0.00	XXX	79300		၁	Nuclr rx, interstit colloid	0.00	0.00	Ϋ́	00.0	XXX
		Tumor imaging, whole body	1.07	0.29	0.29	90.0	xxx	79300	IC	C	Nuclr rx, interstit colloid	0.00	0.00	Y.	00'0	XXX
		Abscess imaging, ltd area	0.73	3.65	ΑN	0.05	XXX	79300	56	Ą	Nuclr rx, interstit colloid	1.60	0.48	0.48	0.12	XXX
78805 TC		Abscess imaging, Itd area	0.00	3.45	NA	0.00	XXX	79403		¥	Hematopoietic nuclear tx	2.25	2.43	NA	0.14	XXX
	¥.	Abscess imaging, Itd area	0.73	0.20	0.20	0.04	XXX	79403	JC	4	Hematopoietic nuclear tx	0.00	1.79	NA	0.01	XXX
78806	V	Abscess imaging, whole body	0.86	7.19	NA	0.05	XXX	79403	26	∢	Hematopoietic nuclear tx	2.25	0.64	0.64	0.13	XX
78806 IC		Abscess imaging, whole body	0.00	96.9	NA	00.0	XXX	79440		٧	Nuclear rx, intra-articular	1.99	1.66	NA	0.14	XXX
		Abscess imaging, whole body	0.86	0.23	0.23	0.05	XXX	79440	JC	٧	Nuclear rx, intra-articular	0.00	<u>4</u>	NA	10.0	XX
	<	Nuclear localization/abscess	1.09	7.11	NA	0.07	XXX	79440	56	Α	Nuclear rx, intra-articular	1.99	0.62	0.62	0.14	XXX
78807 TC		Nuclear localization/abscess	00.0	6.85	NA	0.00	XXX	79445		ပ	Nuclear rx, intra-arterial	00.0	NA	Ν	00'0	XXX
		Nuclear localization/abscess	1.09	0.26	0.26	90.0	XXX	79445	C	၁	Nuclear rx, infra-arterial	0.00	NA A	Ϋ́	00.0	XXX
78808	¥	Iv in ra drug dx study	0.18	0.84	Ν	10.0	XXX	79445	56	¥	Nuclear rx, intra-arterial	2.40	0.62	0.62	0.15	XXX
78811	ပ	Pet image, ltd area	0.00	0.00	ΝĀ	0.00	XXX	19999		၁	Nuclear medicine therapy	0.00	0.00	Ϋ́	0.00	XXX
78811 TC	C C	Pet image, ltd area	00.0	0.00	Y.	0.00	XXX	19999	JC	Ç	Nuclear medicine therapy	00.0	0.00	ΝĀ	0.00	XXX
78811 26	A A	Pet image, ltd area	1.54	0.45	0.45	0.14	XXX	79999	26	၁	Nuclear medicine therapy	0.00	00.0	00.0	00.0	XXX
78812	Ų	Pet image, skull-thigh	0.00	0.00	NA	0.00	XXX	80055		_	Obstetric panel	0.00	0.00	0.00	0.00	XXX
78812 TC	C	Pet image, skull-thigh	0.00	0.00	Ϋ́	0.00	XXX	80500		٧	Lab pathology consultation	0.37	0.17	0.11	0.02	XXX
78812 26	, A	Pet image, skull-thigh	1.93	0.54	0.54	0.13	XXX	80502		¥	Lab pathology consultation	1.33	0.41	0.36	90.0	XXX
78813	ں	Pet image, full body	00.0	0.00	ΥN	0.00	XXX	83020		×	Hemoglobin electrophoresis	00.0	0.10	NA	0.00	XXX
78813 TC	C	Pet image, full body	00.0	0.00	NA	0.00	XXX	83020	56	٧	Hemoglobin electrophoresis	0.37	0.15	0.15	0.02	XXX
78813 26	ý A	Pet image, full body	2.00	0.55	0.55	0.14	XXX	83912		×	Genetic examination	00.0	80.0	NA	0.00	XXX
78814	ပ	Pet image w/ct, lmtd	00.0	0.00	Y Z	0.00	XXX	83912	56	K	Genetic examination	0.37	0.13	0.13	0.02	XXX
78814 TC	C	Pet image w/ct, lmtd	0.00	0.00	NA	0.00	XXX	84165		×	Protein e-phoresis, serum	0.00	0.10	NA	0.00	XXX
78814 26	Ą	Pet image w/ct, lmtd	2.20	0.61	19.0	0.15	XXX	84165	56	¥	Protein e-phoresis, serum	0.37	0.14	0.14	0.02	XXX
78815	၁	Pet image w/ct, skull-thigh	0.00	0.00	Ν	0.00	XXX	84166		×	Protein e-phoresis/urine/csf	0.00	0.10	NA	0.00	XXX
J.C.	T codes an	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medi	cal Associat	ion. All Rig	hts			CPT co	des and d	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	vmerican Medi	cal Associati	on. All Righ	ots	
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JI,	values are	If values are reflected for codes not payable by Medicare, please note that these values have been	re, please note	that these v	alues have t	een			- If value	s are refle	If values are reflected for codes not payable by Medicare, please note that these values have been	are, please note	that these v	alues have b	Gen Gen	
as . T	e budget n	established as a contrest to me general proble and are not used for incorreac payment. The budget neutrality reduction from the chiropractic demonstration is not reflected it.	t used for ivic emonstration	is not reflect	payment. reflected in the RVUs for CPT	Us for CPT			The bu	dget neutr	statushed as a countesy to the general proofs and are not used for received by purent. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflect	ed in the RV	Us for CPT	
code	s 98940, 5	codes 98940, 98941, and 98942. The required reduction will only be reflect	will only be 1	eflected in t	ed in the files used for	for			codes 98	940,9894	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be r	reflected in th	e files used	for	
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 | 900 | 0.00 | 90.08
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RVUs ^{2,3} | NA | 0.20 | YZ. | Y
Z | 0.28 | Y Z
 | 0.19 | X | X
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 | g S | 0.35 | NA N | YZ. | ΥN | 0.16
 | Ϋ́Z | ξ <u>ς</u> | Y X | NA
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A | Z C | Z
Z | ΝA | 0.18
 | Z Z | 0.47 | 0.60
 | 0.57 | Z | Ϋ́Z
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| PE
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RVUs ^{2,3} | 1.31 | 0.20 | 1.89 | 1.61 | 0.28 | <u> </u>
 | 0.19 | 1.38 | 1.02 | 0.36 | 0.31
 | 0.21 | 0.35 | 1.06 | 0.85 | 89.0 | 91.0
 | 0.85 | 69.0 | 1.00 | 0.81 | 0.19 | 0.85 | 0.23
 | 2.14 | 1.66 | 1.79 | 1.62 | 0.18
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RVUs ^{3,3} | 00.0 | 0.56 | 0.76 | 0.00 | 0.76 | 0.36
 | 0.00 | 1.18 | 0.00 | 1.18 | 0.26
 | 0.00 | 0.47 | 0.00 | 0.50 | 0.00 | 0.50
 | 0.50 | 0.00 | 0.76 | 0.00 | 97.0 | 0.60 | 0.60
 | 1.39 | 0.00 | 0.77 | 0.00 | 0.77
 | 0.00 | 1.36 | 69'1
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on will only be |
| Description | Cytopath fl nongyn, filler | Cytopath fi nongyn, filter | Cytopath fl nongyn, sm/fltr | Cytopath fi nongyn, sm/fltr | Cytopath fl nongyn, sm/fitr | Cytopath, concentrate tech
 | Cytopath, concentrate tech | Cytopath, cell enhance tech | Cytopath, cell enhance tech | Cytopath, cell enhance tech | Forensic cytopathology
 | Forensic cytopathology | Cotonish c/v intermet | Cytopath, CV, meanual | Cytopath smear, other source | Cytopath smear, other source | Cytopath smear, other source
 | Cytopath smear, other source | Cytopath smear, other source | Cytopath smear, other source | Cytopath smear, other source | Cytopath smear, other source | Cytopathology eval of fina | Cytopathology eval of tha
 | Cytopath eval, fina, report | Cytopath eval, fina, report | Cell marker study | Cell marker study | Cell marker study
 | Flowcytometry/ tc, i marker
Flowcytometry/tc, add-on | Flowcytometry/read, 2-8 | Flowcytometry/read, 9-15
 | Flowcytometry/read, 16 & > | Cytopathology procedure | Cytopathology procedure
 | Cytopathology procedure | descriptions only are copyright 2009 | The Yusus zar prefected for codes not payable by Medicare, please note luith tiese values have been sestablished as a countesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the R VUs for CPT Medicare payment, and 98942. The required reduction will only be reflected in the files used for Medicare navment. |
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| CPT ^{1.3} /
HCPCS | 88106 | 90188 | 88107 | 88107 | 88107 | 88108
 | 88108 | 88112 | 88112 | 88112 | 88125
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 | 19188 | 19188 | 88162 | 88162 | 88162 | 88172 | 88172
 | 88173 | 88173 | 88182 | 88182 | 88182
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| Global | XXX | XXX | XXX | XXX | XXX | Y
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RVUs ^{2,3,4} | 0.03 | 00'0 | 0.02 | 0.00 | 0.02 | 70.0
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 | 0.00 | 0.00 | 0.02
 | 0.03 | 0.00 | 0.03
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PE
RVUs ^{2,3} | 0,14 | N. | 0.15 | V | 0.15 | 0.18
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RVUs ^{2,3} | 0.14 | 0.10 | 0.15 | 0.10 | 0.15 | 5 Y
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Description RVU | s/csf | | Western blot test 0.37 | | |
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 | 0.37 | | skin test | Histoplasmosis skin test 0.00 | 0000
 | Dark field examination 0.37 | |
 | | | S
 | Cytopath fl nongyn, filter 0.56 | descriptions only are copyright 2009 American Medic | electre for codes but payable by Medicare, please no
outresy to the general public and are not used for M
railty reduction from the chiropractic demonstration
14, and 98942. The required reduction will only be |
| | Protein e-phoresis/urine/csf | Western blot test | Western blot test | | Protein, western blot test | Blood smear interpretation
 | | | | |
 | | | 0.00 | 0.37 | 0.00 | 0.37
 | Serum immunoelectrophoresis 0.00 | 0.37 | 0.37 | Immunoelectrophoresis assay 0.00 | 0.42 | 0.00 | 0.00
 | 0.37 | 0.00 | | | 0000
 | | | Smear, special stain
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eed as a courtesy to the general public and are not used for M
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day, 58941, and 58942. The required reduction will only be
programment. |
| Description | A Protein e-phoresis/urine/csf | X Western blot test | Western blot test | Protein, western blot test | Protein, western blot test | Blood smear interpretation
 | Education merperation | | A Clotting assay, whole blood | |
 | | | 0.00 | 0.37 | X Fluorescent antibody, titer 0.00 | Fluorescent antibody, titer 0.37
 | X Serum immunoelectrophoresis 0.00 | Serum iminumoelectrophoresis 0.37 | Other immunoelectrophoresis 0.37 | X Immunoelectrophoresis assay 0.00 | Immunoelectrophoresis assay 0.42 | X Immunofix e-phoresis, serum 0.00 | 0.00
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 | Cytopath fl nongyn, filter | CPT codes and descriptions only are copyright 2009 American Medic
Reserved. | If values are reflected for codes to grayable by Medicare, please one that these values have been
established as a countresy to the general public and are not used for Medicare payment. The budget neurality reduction from the chiropractic demonstration is not reflected in the RVUs
codes 9840, 9894, and 98942. The required reduction will only be reflected in the files used for
Medicare neurons. |
| | Fecility Mail: PE PF PE PF PE PF | Fediny Facility Matter CPT ¹³ (1995) Fediny Facility Practics (1995) Fediny Facility Processing Federal Reviews (1995) Federal Reviews (| Facility Practice Pacific Paci | Pectury Pacity Pacity | Per Per | Per Per | Particle Particle | Particle Particle | Pacification Paci | Period P | Particle Particle | Particle Particle | Particle Particle | Pacification | Pacification Parallel Pacification Pacification Pacification Pacification Pacification Pacification P | Particle Particle | Particle Particle | Particle Particle | Particle Particle | Pacification | Pacification | Particle Particle | Paginal | Pacing Principles Paci | Part Part | Part Part | Patrick Patr | Particulary Particulary | Partial Partial Control Partial CPT-1 (Control Partial) FORTIAL Partial Partial FORTIAL Partial Par | Falling Pauling Paul | RATION PARTILLA CORPARA COPTION Mode COPTION Mode COPTION Mode COPTION PARTILLA PARTILLA PARTILLA COPTION COPTION PARTILLA PARTILLA COPTION COPTION PARTILLA PARTILLA | Fraging Programs Corputal Month Corputal Month Corputal Month Corputal Month Programs Programs <t< td=""><td>NA OLD XXX SS 100 CPT*** Mode of Mark CPUTA** POWER** POWER**<</td><td>Figure Printing Printing States COPT-1 (No. 14) States Description Printing Printing Printing</td><td>Figure 1 Profited of the control of the c</td><td>PARTIAL PROMESTAL CONTRICTOR COPTA (VILLA) (Control of the control of t</td><td>PARTIAL PROMINES PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES PARTIAL PROMINES<td> Comparison Copy C</td></td></t<> | NA OLD XXX SS 100 CPT*** Mode of Mark CPUTA** POWER** POWER**< | Figure Printing Printing States COPT-1 (No. 14) States Description Printing Printing Printing | Figure 1 Profited of the control of the c | PARTIAL PROMESTAL CONTRICTOR COPTA (VILLA) (Control of the control of t | PARTIAL PROMINES PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES COPT-15 Mode of PARTIAL PROMINES PARTIAL PROMINES <td> Comparison Copy C</td> | Comparison Copy C |

1			-	Physi- clan	Non- Facility	Facility	-leW		S. France				Physi- clan	Non- Facility	Facility	Mai-	
HCPCS	Mod	Status	Description	RVUs.13	RVUs.23	RVUs.	RVUs ^{2,3,4}	Global	HCPCS	Nod S	Status	Description	RVU.	RVUs ^{2,3}	RVUs ^{2,3}	RVUs 2.3.4	Global
88291		<	Cyto/molecular report	0.52	0.25	0.25	0.02	XXX			A	Comprehensive review of data	2.50	2.78	1.02	0.11	XXX
88299		O	Cytogenetic study	0.00	0.00	0.00	0.00	XXX	88329		A P	Path consult introp	0.67	69.0	0.25	0.03	XXX
88300		A	Surgical path, gross	0.08	0.54	ΝΆ	0.00	XXX	88331		A	Path consult intraop, 1 bloc	1.19	1.25	Ϋ́	0.0	XXX
88300	C	٧	Surgical path, gross	0.00	0.51	Υ	00:0	XXX	88331	TC	A	Path consult intraop, 1 bloc	0.00	0.79	NA	0.00	XX
88300	56	٧	Surgical path, gross	80.0	0.03	0.03	00:0	XXX		56	A P	Path consult intraop, 1 bloc	1.19	0.47	0.47	0.04	XXX
88302		∢	Tissue exam by pathologist	0.13	1.16	NA	0.01	XXX			A	Path consult intraop, addÆl	0.59	0.49	NA	0.03	XXX
88302	C	٧	Tissue exam by pathologist	0.00	1.12	Ν	00'0	XXX		TC	A F	ath consult intraop, add£1	0.00	0.27	NA	0.00	XX
88302	56	٧	Tissue exam by pathologist	0.13	0.05	0.05	0.01	XXX		56	A P	Path consult intraop, addÆl	0.59	0.22	0.22	0.03	XXX
88304		٧	Tissue exam by pathologist	0.22	1.39	NA	0.0)	XXX	88333		A B	intraop cyto path consult, 1	1.20	1.34	ΝA	90'0	XXX
88304	70	¥	Tissue exam by pathologist	0.00	1.31	NA	0.00	XXX	88333	TC	A A	intraop cyto path consult, 1	0.00	68'0	X X	0.00	XXX
88304	56	¥.	Tissue exam by pathologist	0.22	0.08	0.08	10:0	XXX	88333	56	Λ.	intraop cyto path consult, I	1.20	0.45	0.45	0.05	XX
88305		٧	Tissue exam by pathologist	0.75	1.91	ΝA	0.03	XXX	88334		A L	ntraop cyto path consult, 2	0.73	0.83	٧Z	0.03	XXX
88305	10	¥	Tissue exam by pathologist	0.00	99.1	ΑN	0.00	XXX		IC	A L	intraop cyto path consult, 2	0.00	0.55	NA	0.00	XXX
88305	76	¥	Tissue exam by pathologist	0.75	0.26	0.26	0.03	XXX	88334	56	A II	ntraop cyto path consult, 2	0.73	0.28	0.28	0.03	XX
88307		٧	Tissue exam by pathologist	1.59	4.25	Y.	0.07	XXX	88342		A	mmunohistochemistry	0.85	18 .	ΝA	0.04	XXX
88307	70	¥	Tissue exam by pathologist	0.00	3.66	NA	0.00	XXX		TC	A B	mmunohistochemistry	0.00	1.54	NA VA	00.0	XXX
88307	26	∢	Tissue exam by pathologist	1.59	09'0	09.0	0.07	XXX	88342	26	A L	mmunohistochemistry	0.85	0.28	0.28	0.04	XXX
88309		4	Tissue exam by pathologist	2.80	6.14	X	0.13	XXX	88346		A L	immunofluorescent study	0.86	1.73	NA	0.04	XXX
88309	TC	٧	Tissue exam by pathologist	0.00	5.09	AN.	10.0	XXX		77	A I	mmunofluorescent study	0.00	1.45	NA A	00.0	XXX
88309	79	4	Tissue exam by pathologist	2.80	1.06	90:1	0.12	XXX		26	A	mmunofluorescent study	0.86	0.28	0.28	0.03	XXX
88311		: <	Decalcify tissue	0.24	0.25	X	0.0	XXX				mmunofluorescent study	0.86	1.13	ΑZ	0.03	XXX
88311	TC	<	Decalcify tissue	0.00	0.16	Y.	0.00	XXX		IC I	_	immunofluorescent study	0.00	0.92	ΥZ	0.00	XXX
88311	56	٧	Decalcify tissue	0.24	60:0	0.09	0.01	XXX		26	_	immunofluorescent study	0.86	0.21	0.21	0.03	XXX
88312		<	Special stains	0.54	2.13	N	0.02	XXX	88348		A E	Electron microscopy	1.51	(5.15	Ϋ́	0.07	XXX
88312	TC	٧	Special stains	0.00	1.96	NA	0.00	XXX	88348	TC	A	Electron microscopy	0.00	14.67	ΥZ	0.00	XXX
88312	56	₹	Special stains	0.54	0.18	0.18	0.02	XXX		56	A	Electron microscopy	1.51	0.49	0.49	0.07	XXX
88313		¥	Special stains	0.24	1.67	NA	0.01	XXX	88349		A S	Scanning electron microscopy	97.0	8.92	NA NA	90.0	XXX
88313	IC	¥	Special stains	0.00	1.59	Y.	0.00	XXX	88349	TC	A S	Scanning electron microscopy	0.00	8.62	NA	0.00	XXX
88313	26	4	Special stains	0.24	90.0	80.0	0.01	XXX	88349	56	A S	Scanning electron microscopy	0.76	0.30	0.30	0.04	XXX
88314		٧	Histochemical stain	0.45	1.72	NA	0.02	XXX	88355		¥	Analysis, skeletal muscle	1.85	2.63	NA	0.05	XXX
88314	TC	¥	Histochemical stain	0.00	1.56	NA	0.00	XXX		TC	A	Analysis, skeletal muscle	0.00	2.23	NA	0.01	XXX
88314	56	٧	Histochemical stain	0.45	0.17	0.17	0.02	XXX	88355	26	۷ ۷	Analysis, skeletal muscle	1.85	0.40	0.40	0.05	XXX
88318		¥	Chemical histochemistry	0.42	2.14	NA	0.02	XXX	88356		۷ ۷	Analysis, nerve	3.02	4.02	NA	0.18	XXX
88318	TC	∢	Chemical histochemistry	0.00	2.01	Ν	0.00	XXX	88356	IC	۷ ۷	Analysis, nerve	0.00	3.52	NA	0.01	XXX
88318	56	4	Chemical histochemistry	0.42	0.12	0.12	0.02	XXX	88356	56	۷ ۷	Analysis, nerve	3.02	0.50	0.50	0.17	XXX
88319		4	Enzyme histochemistry	0.53	3.01	NA	0.03	XXX			∀	Analysis, tumor	0.95	76.0	NA	0.05	XXX
88319	TC	٧	Enzyme histochemistry	0.00	2.82	NA	0.00	XXX		TC	₹ *	Analysis, tumor	0.00	0.78	NA	0.00	xxx
88319	56	¥	Enzyme histochemistry	0.53	0.19	61.0	0.03	XXX		26	A.	Analysis, tumor	0.95	61.0	61.0	0.04	XXX
88321		٧	Microslide consultation	1.63	0.79	0.58	0.07	XXX			A	fumor immunohistochem/manual	1.10	2.09	NA	0.05	XX
88323		¥	Microslide consultation	1.83	1.88	ΝĀ	0.08	XXX		TC	A T	fumor immunohistochem/manual	0.00	1.75	Ν	0.00	XX
88323	C	4	Microslide consultation	0.00	1.38	Ϋ́	0.01	XXX	88360	26	A T	Fumor immunohistochem/manual	1.10	0.35	0.35	0.05	XXX
88323	56	4	Microslide consultation	1.83	0.50	0.50	0.08	XXX	88361		A T	I umor immunohistochem/comput	1.18	2.50	NA	90'0	XXX
	CPT	codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medi	cal Associa	tion. All Ri	ghts		_	PT code	s and des	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associati	on. All Righ	ls	
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	It vali	ues are re	It values are reflected for codes not payable by Mcdicare, please note that	e, please not	e that these	these values have been	peen		-	r values	re retiec	If values are reflected for codes not payable by Medicare, please note that these values have occur	re, piease nou	e mar mese v	aines nave o	co	
	establis	shed as a	established as a courtesy to the general public and are not used for Medicare	used for Me	dicare payment	nent.	payment.	,	3.68	tablished Cho burda	as a com	established as a courtesy to the general public and are not used for Medicare payment.	t used for Me	dicare payme	od in the DA	Ta Car	
	Dade	38040 980 38940 980	The dudget neutrality reduction most use chargoners among a port of the reduction will only be reflected in the files used for	will only be	reflected in	the files use	d for		- 5	des 9894	0.98941	rectionages used and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in th	re files used	12 10 C	
	Medica	Medicare payment.	int.	Î			į		X	edicare p	yment.		ĺ				
	Globa	a) totals fo	Global totals for malpractice RVUs may not sum due to rounding	rounding.) _*	Global tor	als for m	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.				

- inc															0.00	0.00	0.00	0.00	0.01	0.01	0.01		10.0	10:0	0.01	X 00:0 0:00					0.05	0.05	0.34 0.07 X	0.00	0.32 0.10	500	0.00	0.35 0.00 X:	000		lues have been	nt. d in the RVUs for CPT	e files used for	
Facility PE RVUs ^{2,3}	6.44	7.67	6.41	189	6.77	0.37	910	0.0	00.0	000	0.00	0.00	0.00	0.00	0.00	0.00	0.00	00'0	0.42	0.16	0.27	0.15	0.17	0.26	0.12	0.00	0.00	31	1.49	0.47	0.59	0.38	0.69	0.49	0.63	120	0.71	0.40	10:0	rdical Association	ote that these va	dedicare paymen m is not reflecte	e reflected in the	
cian Work RVUs ²³	0.19	0.79	0.21	0.94	0.85	000	000	000	000	000	0.00	0.00	0.00	00.0	0.00	0.00	0.00	00:00	0.17	0.15	0.17	0.15	0.15	0.17	0.15	0.00	000	2.80	3.01	1.21	1.37	1.86	2.02	67.7	2.93	770	÷.	7.13	00.0	American Me	icare, please n	not used for N c demonstratic	ion will only b	e to rounding.
Description	Sample stomach contents	Sample stomach contents	Sample stomach contents	Sample stomach contents	Cample stomach contents	South meaning collection	Collect sweat for feet	Darkology for propositive	Human io im	Himan io iv	Botulinum antitoxim	Botulism ig. iv	Cmv ig, iv	Rsv ig, iv	Rh ig, full-dose, im	Rh ig, iv	Tetanus ig, tm	Immune globulin	Immune admin 1 inj, < 8 yrs	Immune admin addl inj, < 8 y	fmmune admin o or u, < 8 yrs	Immune admin o/n, addl < 8 y	Imminization admin. each add	Immune admin oral/nasal	Immune admin oraVnasal addl	Dtap-hep b-ipv vaccine, im	inactivated je vacc im	Psy dx interview	Intac psy dx interview	Psytx, office, 20-30 min	Psytx, off, 20-30 min w/e&m	Psytx, off, 45-50 min	Psyrx, off, 45-50 min w/e&m	Psylx, office, 75-80 min	FSyck, OH, 75-80, W/c&m	Inter potes, on, 20-50 min	Turac poyer, 20-50, wrecking	Infac poyes, on, 45-50 min	Inter words off 75 20 min	CPT codes and descriptions only are converient 2009 American Medical Association All Biohts	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPF	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding
Status	4	۷	. ∢	₹ 4	: 4	(⊲		: د) 					-					∢	∢:	oz i	∡ ∢	< ∢	: œ	~	-		- ∢	. ∢	٧	∢	∢	< →	< →	< <	(•	< <	(∢	; ∢	indes and	ed. Les are re	hed as a oudget net	codes 98940, 9894 Medicare payment	l totals ro
Po X																																								CPT	Reserved If values	establis The b	codes 9	Clops
CPT ^{1,2} /HCPCS	89132	52168	91 108	89140	80141	00008	89730	80240	90240	6200	90287	90288	90291	90379	90384	90386	90389	66806	90465	90466	90467	90468	90472	90473	90474	90723	90/38	90801	90802	90804	90805	90806	90807	80808	60806	00811	1000	1806	K1900					
Globai	XXX	XXX	XXX	XXX	XXX	XXX	XXX	200	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	xxx	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	Y Y X	X X X	XXX	×××	XXX	XXX			-		
Mal- Practice RVUs ^{2,3,4}	00'0	0.05	0.13	100	0.10	90.0	00.0	20.0	80.0	000	0.07	0.07	0.00	90.0	0.00	0.02	0.00	0.02	0.07	0.00	0.07	0.00	000	000	0.00	00'0	0.07	0.02	0.09	0.01	0.08	0.00	0.00	0.00	0.00	0.00	0.02	0.00	70.0	iohts	e been	R VUs for CP	ed for	
Facility PE RVUs ^{2,3}	X	0.34	N N	Z	0.77	; Z	C 4	0.17	5 Z	Z Z	0.33	X	Z	0.28	N.	0.15	V Z	0.15	K Z	NA.	0.60	ď ž	0.21	Ϋ́	NA.	0.00	K Z	0.50	NA	NA	0.55	Ν	AN S	90.0	C N	177	5.0	0.44	040	fical Association All Rights	e values hav	ment. ected in the	reflected in the files used for	
Facility PE RVUs ^{2,3}	2.16	0 34	\$ 22	4 45	0.77	202	2,66	2.00	4 00	4 50	0.33	4.07	3.80	0.28	0.10	0.15	0.10	0.15	3.59	2.99	0.60	2.43	0.21	00.0	0.00	00.00	23.03	05 0	14.49	13.94	0.55	0.00	0.00	0.00	54.0	0.10	1.0	6 80	6.9	edical Assoc	ote that thes	Medicare pay on is not refi		
Work	0.00	8-	2.17	000	21.5	1.7	0.00	00.0	1 30	900	1.30	1.40	0.00	1.40	0.00	0.37	00.0	0.37	1.56	0.00	95.	81.1	0.00	0.00	000	0.00	0.50	00.0	88.1	0.00	1.88	00'0	0.00	90.0	04.1	0.00	0.37	0.00	0.00	American M	are, please	tot used for l demonstrati	n will only t	to rounding.
Description	Tumor immunohistochem/comput	umor immunohistochem/commu	Name teasing preparations	Very teasing preparations	Correction propagations	serve teasing preparations	notice hybridization (fish)	month by Condition (1921)	insita nyozitazanou (nan) neini hubiidization anto	nsitu ayon menanon, amo	nsitu hybridization, auto	nsitu hybridization, manual	nsitu bybridization, manual	nsitu hybridization, manual	Protein, western blot tissue	Protein, western blot tissue	Protein analysis w/probe	Protein analysis w/probe	Microdissection, laser	Microdissection, laser	Microdissection, laser	Microdissection, manual	Microdissection manual	Eval molecular probes, 11-50	Eval molecular probes, 11-50	Eval molecular probes, 11-50	Eval molecul probes, 51-250	Eval motecut proces, 51-250 Eval motecut proces, 51-250	Eval molecul probes, 251-500	Eval molecul probes, 251-500	Eval molecul probes, 251-500	Surgical pathology procedure	Surgical pathology procedure	Surgical pathology procedure	Chect for mai hyperthermia	majorate time er jatan	exam, synovian mind crystals	Sample infestinal contents	County contract contents	CPT codes and descriptions only are convright 2009 American Med	Reserved. ? fralues are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding.
Deac	Tumor immun	Tumor imm	North teach	Nerve teas	Nonce to	facine had	their h	Tanger 1	facita h	Incita	Insitu h	Insitub	(nsitu l	Insitut	Protei	Prote	Prote	Prot	Χ̈́	Ϋ́	Ž.	Ž.	Ž	E A	Eva	Eva	Eva	d ti	Eval	Eval	Eva	Sur	Smi	3 6	2 6		EX S	Samp	Comp	d in	lected 1	ourtesy rality re	41, and	r malpra
Slatus							insurant A	~ ~			A Insituh	_	_	A Insitut	_			A Prot					A Mic			_		A Eve	-	_	A Eva	C Sun	C Sung		A Che				Sound	odes and descrip	ed. es are reflected i	hed as a courtesy idget neutrality re	8940, 98941, and re payment.	i totals for malpra
_	A	. 4	. ~		; <	ς <	_	< <	ζ 4		< ∢	: ≺	: <	_	_			-	∀	- *		< -		(C		_	∢ •		٠.	_ 	26 A Eva	υ	TC C Sung	. ن	-	< -				POT rocks and descript	Reserved. If values are reflected in	established as a courtesy. The budget neutrality re	codes 98940, 98941, and Medicare payment.	' Giobal totals for malpra

lity Mal-																																						00.00		0.10	0.00
IIIY Facility																															18 2.88		9,0							10.10	11 9.41
Non- Facility PE PE																																				0.40	3.7	3.28	0.42	10.10	9.41
Physi- clan Work RVus ² .	12.52	8.34	5.50	5.18	4.26	3.15	10.56	9.14	8.69	4.26	0.35	0.30	0.29	0.14	1.84	0.00	0.73	0.00	0.73	1.25	0.00	1.25	1.50	0.00	1.50	1.46	146	1.44	0.00	1.44	1.4	0.00	1.44	0.91	00.00	0.91	0.97	0.00	0.97	1.59	0.00
Description	Esrd srv, 4 vsts p mo, 12-19	Esrd srv 2-3 vsts p mo 12-19	Esrd serv, 1 vst p mo, 12-19	Esrd srv, 4 visits p mo, 20+	Esrd srv, 2-3 vsts p mo, 20+	Esrd serv, 1 visit p mo, 20+	Esrd home pt, serv p mo, <2	Esrd home pt serv p mo, 2-11	Esrd home pt serv p mo 12-19	Esrd home pt, serv p mo, 20+	Esrd home pt serv p day, <2	Esrd home pt srv p day, 2-11	Esrd home pt srv p day 12-19	Esrd home pt serv p day, 20+	Hemoperfusion	Dialysis procedure	Esophageal intubation	Esophageal intubation	Esophageal intubation	Esophagus motility study	Esophagus motility study	Esophagus motility study	Esophagus motility study	Esophagus motility study	Esophagus motility study	Esophagus motility study	Esophagus motility study	Gastric motility studies	Gastric motility studies	Gastric motility studies	Duodenal motility study	Duodenal motility study	Duodenal motility study	Acid perfusion of esophagus	Acid perfusion of esophagus	Acid perfusion of esophagus	Gastroesophageal reflux test	Gastroesophageal reflux test	Gastroesophageal reflux test	G-esoph reflx 1st w/electrod	G-esoph reflx tst w/electrod
Status	¥	¥.	¥	¥	4	¥	٧	4	4	K	Y	¥	Ą	A	٧	ပ	¥	٧	¥	¥	٧	K	٧	¥	Κ.	∢ <	: ∢	. ≺	¥	¥	ď	¥	∢	K	٧	¥	٧	Ą	K	Ą	¥
Ž																		TC	56		TC	56		7C	56	J.	2 %		TC	56		ည	56		IC	56		10	56		TC
CPT ¹³ / HCPCS	90957	85606	65606	09606	19606	30062	69606	90964	59606	99606	19606	89606	69606	02606	76606	66606	91000	00016	00016	01016	01016	01016	11016	11016	91011	91012	91017	91020	91020	91020	91022	91022	91022	01030	91030	01030	91034	91034	91034	91035	91035
Global	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	XXX	XXX	XXX	XXX	XXX	XXX	000	000	000	000	XXX	000	000	XXX	XXX	XXX	XXX	XXX	XXX													
Mat- Practice RVUs ^{2,3,4}	0.11	0.03	0.05	0.05	0.07	0.08	0.10	0.04	0.05	90'0	0.07	80.0	0.10	90'0	90'0	0.07	0.02	0.02	0.02	0.03	0.10	90:0	90.0	0.10	90.0	0.05	0.00	0.00	0.02	0.05	0.05	0.09	0.00	90.0	0.10	0.77	0.00	0.00	69'0	0.38	0.26
Facility PE RVIJs ^{2,3}	0.55	0.22	0.34	0.28	0.45	0.40	09'0	0.22	0.36	0.30	0.46	0.38	19:0	0.33	0.33	96.0	0.18	0.21	0.19	0.27	0.57	0.37	0.44	69.0	0.28	0.35	000	0.00	0.13	0.30	0.64	0.95	N A	99.0	96'0	8.45	0.00	0.00	6.64	3.71	2.31
Non- Facility PE RVIIs ^{2,3}	101	NA	N.	NA	ΝA	ΝA	NA	Ϋ́	NA	ΥN	NA	NA	NA	0.39	0.41	0.59	0.30	0.27	0.33	0.62	1.47	1.88	0.71	0.95	0.42	0.35	60.0	0.0	0.54	1.23	NA	Ϋ́Z	0.37	Ϋ́	ΝA	8.45	0.00	0.00	6.64	3.71	2.31
Physi- clan Work RVIN ^{2,3}	3.06	1.25	14.1	68.1	2.05	2.83	2.99	1.36	1.52	2.01	2.16	2.94	3.10	1.79	1.83	2.21	0.59	0.59	0.63	0.95	2.84	1.88	1,20	1.90	2.19	0.97	94.7	000	0.41	0.89	1.22	2.11	0.00	1.28	2.16	18.46	00.0	0.00	15.98	8.79	5.95
Description	ntac psytx, 75-80 w/e&m	Psytx, hosp, 20-30 mm	Psytx, bosp, 20-30 min w/e&m	Psytx, hosp, 45-50 min	Psytx, hosp, 45-50 min w/c&m	Psytx, hosp, 75-80 min	Psytx, hosp, 75-80 min w/e&m	Intac psytx, hosp, 20-30 min	Intac psytx, hsp 20-30 w/e&m	Intac psytx, hosp, 45-50 min	Intac psytx, hsp 45-50 w/e&m	Intac psytx, hosp, 75-80 min	Intac psycx, hsp 75-80 w/e&m	Psychoanalysis	Family psytx w/o patient	Family psytx w/patient	Multiple family group psytx	Group psychotherapy	Intac group psytx	Medication management	Narcosynthesis	Electroconvulsive therapy	Psychophysiological therapy	Psychophysiological therapy	Hypnotherapy	Psy evaluation of records	Constitution of report	Psychiatric service/therapy	Biofeedback train, any meth	Biofeedback peri/uro/rectal	Hemodialysis, one evaluation	Hemodialysis, repeated eval	Hemodialysis access study	Dialysis, one evaluation	Dialysis, repeated eval	Esrd serv, 4 visits p mo, <2	Esrd serv, 2-3 vsts p mo, <2	Esrd serv, 1 visit p mo, <2	Esrd serv, 4 vsts p mo, 2-11	Esrd srv 2-3 vsts p mo, 2-11	Esrd srv. 1 visit p mo. 2-11
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Reserved.

If values are effected for codes not payable by Medicare, please note that these values have been stabilished as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 89941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been if yealues are reflected for codes not payable by Medicare, please not used for Medicare payment.

The budget neutrality reducion from the cirinopractic demonstration is not reflected in the RVUs for CPT wades 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

;				Physi- cian	Non- Facility	Facility	¥ E		į				Physi- clan	Non- Facility	Facility	Mai	
CPT"/ HCPCS	Wod	Status	Description	Work RVUs ^{2,3}	RVU*	RVUs ²³	RVUs 3.4	Global	HCPCS	W od	Status	Description	RVUs ^{2,3}	RVUs ^{2,3}	RVUs ^{2,3}	RVUs 23.4	Global
91035	56	٧	G-esoph reflx tst w/electrod	1.59	69:0	69.0	60.0	000	62002		Υ	Eye exam, new patient	0.88	1.18	0.41	0.03	XXX
91037		٧	Esoph imped function test	0.97	3.03	3.03	90.0	000	92004		٧	Eye exam, new patient	1.82	2.04	68.0	0.05	X
91037	77	V	Esoph imped function test	0.00	2.61	2.61	0.00	000	92012		ď	Eye exam established pat	0.92	1.27	0.51	0.03	XXX
91037	56	∢	Esoph imped function test	0.97	0.42	0.42	80.0	000	92014		∀	Eye exam & treatment	1,42	1.78	0.75	0.04	XXX
91038		K	Esoph imped funct test > 1h	1.10	2.43	2.43	0.07	000	92015		z	Refraction	0.38	0.15	0.14	0.02	XXX
91038	TC	٧	Esoph imped funct test > 1h	0.00	1.95	1.95	000	000	92018		¥	New eye exam & treatment	2.50	Ą Z	1.42	80.0	XXX
91038	56	٧	Esoph imped funct test > 1h	1.10	0.48	0.48	0.07	000	92019		٧	Eye exam & treatment	131	Ϋ́	0.58	0.04	XX
91040		٧	Esoph balloon distension tst	76'0	6.23	6.23	0.04	000	92020		Ą	Special eye evaluation	0.37	0.34	0.20	0.01	XXX
91040	TC	∢	Esoph balloon distension tst	0.00	16'5	5.91	0.00	000	92025		¥	Corneal topography	0.35	0.61	19:0	10.0	XXX
91040	56	۷	Esoph balloon distension tst	0.97	0.32	0.32	0.04	000	92025	TC	¥	Corneal topography	0.00	0.42	0.42	0.00	XXX
91052		∢	Gastric analysis test	0.79	2.55	2.55	0.03	000	92025	56	4	Corneal topography	0,35	0.19	61.0	0.01	XXX
91052	TC	<	Gastric analysis test	00.0	2.19	2.19	0.00	000	92060		Ą	Special eye evaluation	69.0	86.0	×	0.02	XXX
91052	56	٧	Gastric analysis test	0.79	0.35	0.35	0.03	000	92060	JC.	٧	Special eye evaluation	0.00	0.62	Ν	0.00	XXX
91055		4	Gastric intubation for smear	0.94	2.92	2.92	0.04	000	92060	56	٧	Special eye evaluation	69.0	0.36	0.36	0.02	XXX
91055	TC	<	Gastric intubation for smear	00.00	2.46	2.46	0.00	000	92065		¥	Orthoptic/pleoptic training	0.37	1,00	NA	10.0	XXX
91055	36	: <	Gastric inhibation for smear	0.94	0.46	0.46	0.04	000	92065	IC	<	Orthoptic/pleoptic training	0.00	0.87	Ϋ́	0.00	XXX
01065	ì	. 4	Breath bydrogen test	0.20	1 55	1 55	0.01	000	92065	26	₩.	Orthontic/nleontic training	0.37	0.13	0.13	0.01	XX
23010	Ú	< <	Densit hydrogen test	000	1 46	97	10:0	000	02020	ì	: ⊲	Eithing of contact lons	0.70	1 12	0.36	000	XXX
91003	2 %	< -	Dicam nymogen test	00.0	90.0	900	0.00	900	03081		< <	Victor Fold examination(c)	91.0	113	A N	100	XXX
91005	07	< ⋅	Dream nymogen test	0.20	60.0	60.0	000	000	19020	Ç	٠.	Visual field examination(s)	000	200	5 2	000	***
91105		Κ.	Gastric intubation freatment	0.37	96.1	60.0	0.02	000	18076	2 ;	< -	Visual beid examination(s)	0.00	0.90	× 2	0.00	33
91110		∢	Gi tract capsule endoscopy	3.64	18.12	ď ;	0.21	XXX	92081	26	∢ .	Visual field examination(s)	0.36	0.17	2 :	10.0	X X X X X X X X X X
91110	2	٧	Gi tract capsule endoscopy	0.00	16.52	Ϋ́	0.01	XXX	92082		K	Visual field examination(s)	0.44	1.55	ď.	0.01	XX
91110	56	¥	Gi tract capsule endoscopy	3.64	1.60	09.1	0.20	XXX	92082	C	¥	Visual field examination(s)	0.00	1.33	V.	0.00	XX
91111		∢	Esophageal capsule endoscopy	00.1	16.32	V	0.05	XXX	92082	56	٧	Visual field examination(s)	0.44	0.22	0.22	0.01	XXX
91111	IC	¥	Esophageal capsule endoscopy	0.00	15.88	N A	0.00	XXX	92083		V	Visual field examination(s)	0.50	1.79	V.	0.01	X
91111	56	٧	Esophageal capsule endoscopy	00.1	4.	0.44	0.05	XXX	92083	C	¥	Visual field examination(s)	0.00	1.52	ΑN	0.00	XX
91120		4	Rectal sensation test	0.97	8.82	8.82	60.0	XXX	92083	56	A	Visual field examination(s)	0.50	0.27	0.27	10.0	X
91120	7	Ą	Rectal sensation test	0.00	8.45	8.45	0.00	XXX	92100		A	Serial tonometry exam(s)	0.92	1.56	0.46	0.03	XX
91120	56	٧	Rectal sensation test	0.97	0.38	0.38	60.0	XXX	92120		¥	Tonography & eye evaluation	0.81	1.21	0.40	0.02	XX
91122		<	Anal pressure record	1.77	3.78	3.78	0.12	000	92130		¥	Water provocation tonography	0.81	1.46	0.44	0.03	XXX
91122	IC	4	Anal pressure record	0.00	3.14	3.14	0.01	000	92135		4	Ophth dx imaging post seg	0.35	0.95	NA	0.01	XXX
91122	56	٧	Anal pressure record	1.77	0.64	0.64	0.11	000	92135	JC	Ą	Ophth dx imaging post seg	0.00	0.76	ΑN	0.00	XXX
91123		æ	Irrigate fecal impaction	00:0	NA	NA	00'0	XXX	92135	56	∢	Ophth dx imaging post seg	0.35	61.0	0.19	0.01	XX
91132		ပ	Electrogastrography	0.00	0.00	Ϋ́	00.0	XXX	92136		Ą	Ophthalmic biometry	0.54	1.69	NA A	0.02	XXX
91132	C	C	Electrogastrography	0.00	00.0	Ϋ́	0.00	XXX	92136	JC	٧	Ophthalmic biometry	0.00	1.38	NA	0.00	XXX
91132	56	¥	Electrogastrography	0.52	0.21	0.21	0.02	XXX	92136	56	A	Ophthalmic biometry	0.54	0.32	0,32	0.01	XX
91133		ပ	Electrogastrography w/test	00:0	0.00	Y.	000	XXX	92140		Ą	Glaucoma provocative tests	0.50	1.09	0.24	0.02	XXX
91133	IC	ပ	Electrogastrography w/test	0.00	0.00	NA V	0.00	XXX	92228		٧	Special eye exam, initial	0.38	0.33	0.20	10.0	XXX
91133	56	¥	Electrogastrography w/test	99.0	0.29	0.29	0.04	XXX	92226		K	Special eye exam, subsequent	0.33	0.32	0.19	10.0	XXX
91299		ပ	Gastroenterology procedure	0.00	00.0	Ϋ́	0.00	XXX	92230		٧	Eye exam with photos	0.60	0.88	0.32	0.02	XXX
91299	TC	Ü	Gastroenterology procedure	00:0	0.00	Ϋ́	0.00	XXX	92235		٧	Eye exam with photos	0.81	2.69	ΝA	0.02	XXX
61766	56	ပ	Gastroenterology procedure	0.00	00.0	0.00	0.00	XXX	92235	C	٧	Eye exam with photos	0.00	2.21	NA	00.0	XXX
	CPTC	odes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Med	ical Associa	tion. All Rig	rhts			, CPT e	odes and o	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Med	ical Associati	on. All Righ	tts	
_	Reserved.	ģ	,							Reserved	d.						
	² If value	ies are ref	² If values are reflected for codes not payable by Medicare, please note that these values have been	e, please not	e that these	values have	peen			f valu	es are refl	If values are reflected for codes not payable by Medicare, please note that these values have been	re, please not	e that these v	alues have b	sen	
- •	establist	hed as a c	established as a courtesy to the general public and are not used for Medicare payment.	used for Me	edicare payn	nent.	•			establist	ed as a co	established as a courtesy to the general public and are not used for Medicare payment	t used for Me	dicare payme	ii.	9	
	The bu	udget neu	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	emonstration	is not reflec	cted in the R	VUs for CPT			The bu	idget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT and 00044 and 00043. The manifest of the chiropractic demonstration is not reflected in the Ethernol CPT.	emonstration	is not reflect	ed in the RV	Us for CPT	
-	codes 92	5940, 985	codes 98940, 98941, and 98942. The required reduction will only be reflected in the tires used that	will only be	m nataaria	me titles me	101			Medicar	Medicare navment	tt, and 20242. The required reduction	will out you	ienected in d	ic incs asca	5	
-	Global	"Global totals for r	recurrant payment. Global totals for maluractive RVIIs may not sum due to rounding.	rounding						Global	totals for	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.				
	1000	I totals to	Halplatine is vesting not some see in	10mmmeg.)		majoracion to the part of the second					

	Global	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ξ <u>;</u>	< >	X X X	XXX	XXX	XXX	XXX	XXX	XXX	000	XX	XXX	XXX	X	ago XXX	XX	XXX	XXX	XX	X	X X	X	XXX	XXX	XX	X	XXX	XXX	XXX	XXX	X	XXX	XXX	XXX	XXX	XX	XXX					
Mai- Practice	RVUs***	0.00	20.0	0.00	9.0	0.00	0.02	00.0	0.00	0.00	0.00	90'0	0.01	0.04	0.02	0.01	0.04	0.02	0.03	0.02	0.00	00'0	000	0.02	0.00	0.02	0.02	0.00	0.0	0.00	0.00	0.01	0.00	0.01	0.01	0.00	0.01	0.01	0.00	hts	xeen	/Us for CPT	10 1	
Facility PE	RVUs ²	61.0	5.0	0	t v	V V	0.12	NA	NA	ΝA	0.00	1.12	80.0	0.38	0.21	0.12	0.78	0.19	0.36	0.21	0.00	0.00	000	N. V	Ϋ́	0.16	NA	Y S	5 Z	Ņ	0.04	Ϋ́	NA S	0.1	¥;	Y.	0.09	Y Z	NA	tion, All Rig	values have b	ted in the RV	me mes used	
Non- Facility PE	RVUs ^{2,3}	0.58	60.0	0.70	0.51	0.26	0.46	0.26	0.00	0.00	0.00	Ϋ́	0.63	3.68	1.37	0.77	5.23	1.27	1.10	1.89	0.00	0.00	89.6	1.34	1.18	91.0	1.52	1.38	0.75	0.71	0.04	1.22	1.12	0.1	17.	=	600	2.17	5.06	lical Associa	te that these	edicare payn 1 is not reflec	reflected in	
Physi- clan Work	RVUs.	0.53	0.37	0.30	90.0	000	0.32	0.00	0.00	0.00	0.00	1.51	0.18	98'0	0.52	0.26	0.84	0.43	0.75	0.55	0.00	0.00	00.0	0.00	0.00	0.40	0.33	0.00	0.50	00'0	0.10	0.26	0.00	0.26	0.23	0.00	0.23	0.29	00'0	American Me	are, please no	demonstration	a will only be	to rounding.
	Description	riting of spectacies	Special spectacles fitting	Special spectacles fitting	Special spectacies fitting	Special speciacies fitting Fve proethesis service	Renair & adjust speciacles	Repair & adjust spectacles	Eye service or procedure	Eye service or procedure	Eye service or procedure	Ear and throat examination	Ear microscopy examination	Speech/hearing evaluation	Speech/hearing therapy	Speech/hearing therapy	Nasopharyngoscopy Nasal function chidian	Facial nerve function test	Laryngeal function studies	Oral function therapy	Spontaneous nystagmus study	Positional nystagmus test	Caloric vestibular test	Optokanetic hystagmus test Sponfaneous nystagmus fest	Spontaneous nystagmus test	Spontaneous nystagmus test	Positional nystagmus test	Positional nystagmus test	Calorio nectibular test	Caloric vestibular test	Caloric vestibular test	Optokinetic nystagmus test	Optokinetic nystagmus test	Optokinetic nystagmus test	Oscillating tracking test	Oscillating tracking test	Oscillating tracking test	Sinusoidal rotational test	Sinusoidal rotational test	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	istabilished as a courtesy to me general public and are not used for includer payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.	Global totals for malpractice RVUs may not sum due to rounding.
	Status	Z, (m i	n a	n c	o go	z	.	C	၁	ပ	4	٧	<	٧	∢ .	∢ <	< <	<	V	œ.	m ;	x 1 0	n ∢	۷.	٧	A	∢ .	< <	: <	K	٧	∢ .	¥	٧	¥	A	¥	¥	odes and o	ed. Les are refi	ned as a conditional	codes 98940, 9894 Medicare payment	i totals for
	Mod									TC	76														TC	56		ည ၃	07	TC	56		IC	56		IC	56		TC	CPT c	Reserved.	The bu	Medica	⁴ Globa
CPT ^{1.3} /	HCPCS	92542	92352	65526	92354	92220	92370	92371	92499	92499	92499	92502	92504	92506	92507	9526	92511	92516	92520	92526	92531	92532	92533	92554	92541	92541	92542	92542	92542	92543	92543	92544	92544	92544	92545	92545	92545	92546	92546					
	Global	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX			PT		
Mal- Practice																																										\overline{G}		
ъ.	RVUs	0.02	0.03	0.00	50.0	0.00	200	0.01	0.02	000	0.02	0.04	0.00	0.03	0.03	0.00	0.03	000	000	10.0	00.0	0,01	0.01	0.00	0.02	0.00	0.02	0.02	0.00	0.0	0.03	0.04	0.01	0.02	0.02	0.00	0.00	0.02	0.03	Lights	e peen	RVUs for (ed tor	
Facility PE P	_				0.05												0.58 0.03											0,47 0,02		0.55 0.04						NA 0.00	NA 0.00	0.14 0.02	0.17 0.03	ation. All Rights	e values have been	ment. seted in the RVUs for (the tiles used for	
_	RVUs.3	0.48	¥.	NA C	0.05		0.22	0.11	NA	NA	0.47	¥'N	Ϋ́	0.33		NA.		Y Z	0.08	NA	NA	0.10		¥2 0	N AN	NA	0.36	0,47		0.55	0.50	0.25	0.19		0.07	A'N	NA	0.14	0.17	dical Association. All Rights	ote that these values have been	dedicare payment.	e reflected in the tyles used for	
Facility PE	RVUs23 RVUs23	0.48	3.11 NA	4.40 NA	0.65 0.65	4 4 2	022 022	0.29 0.11	1.36 NA	0.89 NA	0.47 0.47	1.49 NA	1.16 NA	0.33 0.33	2.94 NA	2.36 NA	0.58	AN 80 :	0.08	1.25 NA	1.15 NA	0.10 0.10	¥ ž	0.82 NA 0.10	N AN	2.09 NA	0.36 0.36	2.30 0,47	0.43	1.85 0.55	1.75 0.50	0.25	1.48 0.19	2.00 0.40	2.22 0.07	0.95 NA	0.82 NA	0.14	0,56 0.17	merican Medical Association. All Rights	ire, please note that these values have been	of used for Medicare payment. lemonstration is not reflected in the RVUs for (a will only be reflected in the tiles used for	o rounding.
Non- Facility Facility PE PE	Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3}	Eye exam with photos 0.48 0.48 0.48	A legangiography 1.10 5.11 NA	A icg angiography 0.00 4.40 NA	icg angiography 1.10 0.65 0.65	1.32 NA 1.30 NA	A Eve exam with rhotos 0.50 1.50 1.50	A Ophthalmoscopy/dynamometry 0.20 0.29 0.11	Eye muscle evaluation 0.81 1.36 NA	Eye muscle evaluation 0.00 0.89 NA	A Eye muscle evaluation 0.81 0.47 0.47	Electro-oculography 0.81 1.49 NA	A Electro-oculography 0.00 1.16 NA	Electro-oculography 0.81 0.33 0.33	Electroretinography 1.01 2.94 NA	A Electroretinography 0.00 2.36 NA	Electroretinography 1.01 0.58 0.58	. 08 AN	A Color vision examination 0.17 0.08 0.08	A Dark adaptation eye exam 0.24 1.25 NA	A Dark adaptation eye exam 0.00 1.15 NA	Dark adaptation eye exam 0.24 0.10 0.10	A Eye photography 0.20 0.92 NA	0.82 NA 0.10	A internal even photography 0.66 2.45 NA	A Internal eye photography 0.00 2.09 NA	0.66 0.36 0.36	Internal eye photography 0.81 2.30 0.47	1.28 0.43	1.26 1.85 0.55	0.92 1.75 0.50	0.69 1.31 0.25	0.45 1.48 0.19	0.68 2.00 0.40	Prescription of contact lens 0.45 2.22 0.07	Modification of contact lens 0.00 0.95 NA	Replacement of contact lens 0.00 0.82 NA	Fitting of spectacles 0.37 0.52 0.14	0.47 0.56 0.17	nd descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	sstablished as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chtropractic demonstration is not reflected in the RVUs for CPT	odes 98940, 98941, and 98942. The required reduction will only be reflected in the tites used for Aedicare payment.	Global totals for malpractice RVUs may not sum due to rounding.
Phyat Non- cian Facility Work PE PE	Mod Status Description RVUs ^{2,3} RVUs ^{2,3} RVUs ^{2,3}	26 A Eye exam with photos 0.81 0.48 0.48	A leg angiography 1.10 5.11 NA	TC A legangiography 0.00 4.46 NA	26 A icgangiography 1.10 0.65 0.65	A Engagemental photos 0.44 1.32 INA	26 A Eva-exam with photos 0.00 1.50 103	A Ophthalmoscopy/dynamometry 0.20 0.29 0.11	A Eye muscle evaluation 0.81 1.36 NA	TC A Eye muscle evaluation 0.00 0.89 NA	26 A Eye muscle evaluation 0.81 0.47 0.47	Electro-oculography 0.81 1.49 NA	TC A Electro-oculography 0.00 1.16 NA	26 A Electro-oculography 0.81 0.33 0.33	A Electroretinography 1.01 2.94 NA	TC A Electroretinography 0.00 2.36 NA	A Electroretinography 1.01 0.58 0.58	TC A Color vision evanination 0.00 1.08 NA	26 A Color vision examination 0.17 0.08 0.08	A Dark adaptation eye exam 0.24 1.25 NA	TC A Dark adaptation eye exam 0.00 1.15 NA	26 A Dark adaptation eye exam 0.24 0.10 0.10	A Eye photography 0.20 0.92 NA	A Everahotomonty 0.00 0.82 NA	A Internal eve photography 0.66 2.45 NA	TC A Internal eye photography 0.00 2.09 NA	26 A Internal eye photography 0.66 0.36 0.36	A Internal eye photography 0.81 2.30 0.47	Contact lens titing L.17 1.28 0.43	A Contact lens fifting 1.26 1.85 0.55	A Contact lens fitting 0.92 1.75 0.50	0.69 1.31 0.25	A Prescription of contact lens 0.45 1.48 0.19	A Prescription of contact lens 0.68 2.00 0.40	A Prescription of contact lens 0.45 2.22 0.07	A Modification of contact lens 0.00 0.95 NA	A Replacement of contact lens 0.00 0.82 NA	Fitting of spectacles 0.37 0.52 0.14	N Fitting of spectacles 0.47 0.56 0.17	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved. If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for (codes 98940, 98941, and 98942. The required reduction will only be reflected in the tiles used for Medicare payment.	*Global totals for malpractice RVUs may not sum due to rounding.

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Mak Practice RVIIs ^{2,3,4}	0.09	0.05	0.00	0.00	0.00	0.00	0.00	000	0.00	0.05	0.03	0.05	0.03	0.08	0.03	0.05	0.01	0.05	90.0	10.0	0.00	0.00	0.29	0.00	0.23	0.01	0.12	0.35	0.18	0.09	0.17	0.38	0.00	0.00	0.00	0.10	0.00	0.00	80.0	0.77	0.22	ghts	500	1000	VUs for CP1	5	
Facility PE RVUs ^{2,3}	0.92	0.51	Y N	Ϋ́	Z :	K Z	Y N	Y.	V.	0.59	0.32	0.61	0.29	0.84	0.35	0.71	0.11	0.46	0.51	0.13	Y.	Ϋ́	0.65	0.00	0.88	90.0	0.98	1.7.		1.0	10	2.47	ΑN	NA	Ϋ́	0.60	Ϋ́	ΝA	0.48	5.14	1.40	tion. All Rig	value have	nent.	ted in the R'	me mes ase	
Non- Facility PE PE	1,40	06:0	5.85	2.03	4.70	1.22	2.73	1.79	2.13	3.12	0.32	2.68	0.30	3.35	0.35	0.93	0.18	0.61	0.77	0.21	1.29	1.35	0.98	0.00	3.55	NA	3.18	A ?	V.	t d	NA N	NA	1.27	NA	Y.	09.0	Y.	NA	0.48	Y Z	Ν	lical Associa	to that these	edicare payn	n is not reflect	Tellected at	
Physican cian Work	2.25	1.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.27	0.71	1.27	0.63	1.88	6.79	1.50	0.35	1.15	1.40	0.33	0.00	0.00	1.76	0.00	3.79	0.23	2.25	4.59	3.51	3.78	3.00	7.24	0.00	0.00	0.00	1.80	0.00	0.00	- 44.	14.82	4.16	American Mec	ore estate are	ot used for M	demonstration	a wan oung or	to rounding.
Description	Cochlear implt fup exam 7 >	Reprogram cochlear implt 7 >	Eval for nonspeech device rx	Non-speech device service	Ex for speech device rx, 1hr	Ex for speech device rx addl	Use of speech device service	Evaluate swallowing function	Motion fluoroscopy/swallow	Endoscopy swallow tst (fees)	Endoscopy swallow 1st (fees)	Laryngoscopic sensory test	Eval laryngoscopy sense tst	Fees w/laryngeal sense test	Interprt fees/laryngeal test	Auditory function, 60 min	Auditory function, + 15 min	Tinnitus assessment	Eval and rehab status	Eval aud status rehab add-on	Aud rehab pre-ling hear loss	Aud rehab postling hear loss	Aud brainstem implt programg	Ent procedure/service	Heart/lung resuscitation cpr	Temporary external pacing	Cardioversion electric, ext	Cardioversion, electric, int	Cardioassist, internal	Cardioassist, external	Cath place, cardio brachytx	Dissolve clot, heart vessel	Dissolve clot, heart vessel	Intravasc us, heart add-on	Intravase us, heart add-on	Intravasc us, heart add-on	Intravasc us, heart add-on	Intravase us, heart add-on	Intravase us, heart add-on	Insert intracoronary stent	Insert intracoronary stent	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	(eserved) If when me reflected for codes not massible his Madicura, place note that these values have been	established as a courtesy to the general public and are not used for Medicare payment	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98040, 98041, and 98042. The required requestion will only be reflected in the files used for	nt.	Global totals for malpractice RVUs may not sum due to rounding.
State	A A	¥	В	В	٧	∢	٧	4	A	۷	4	K	٧	<	٧	¥	4	Ą	۷	4	1	,	٧	ပ	4	K	¥	۷ .	∢ .	₹∢	۲ <	₹	₹	Ç	Ö	4	ပ	Ç	٧	Ą	٧	des and		ed as a c	iget neu	paymer:	totals fo
70																																			TC	56		TC	56			CPT co	Seserved If you hou	stablish	The buc	Medicare payment.	Global
CPT ^{1,3} /	92603	92604	92605	92606	92607	80926	92609	92610	92611	92612	92613	92614	92615	92616	92617	92620	92621	92625	92626	92627	92630	92633	92640	92700	92950	92953	92960	92961	0/676	17676	92974	92975	92977	92978	92978	92978	62626	92979	92979	92980	92981	_	DC (1)	Đ,	m (<u>م</u>	4
i doing	XXX	ZZZ	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX				Į.		
Mal- Practice	0.01	0.00	0.02	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	00.0	0.00	0.00	0.00	0.00	0.03	00'0	0.00	0.00	0.02	00.0	000	0.01	0.00	0.01	0.01	0.00	0.01	0.00	0.04	60.0	0.05	Lights	hood	7	ion is not reflected in the RVUs for CPT		
Facility PE DVII.23	0.15	0.12	NA	ΝΆ	0.19	Ϋ́	NA	NA	NA	NA	0.25	NA	NA	AN	ΝΆ	Z	0.08	0.12	0.08	NA	NA	NA	NA	NA	0.33	NA	NA	¥:	NA.	AN C	Y Z	Ϋ́N	NA	0.05	NA	NA	0.15	NA	0.40	00:1	0.40	iation. All B	h.so. har	ment.	ected in the	n me mes ns	
Non- Facility PE	0.11	0.12	2,12	1.93	0.19	0.27	0.65	0.79	0.43	0.68	0.35	98.0	0.82	0.62	0.59	0.31	0.15	0.12	0.08	0.46	0.88	1.23	0.63	0.32	0.49	1.26	0.88	1.48	2.43	27.72	170	0.71	0.65	0.05	1.24	1.09	0.15	1.13	2.12	1.49	0.94	edical Association. All Rights	see that there are have have	Medicare payment.	ion is not reflected in the RVUs	ב ובוופרוכת ו	
Physi- cian Work	0.29	00.0	0.50	00.0	0.50	0.00	0.00	0.00	0.00	00.0	0.60	0.00	0.00	00.0	00:0	00:0	0.20	0.29	0.20	00.00	00.0	0.00	00.0	0.00	0.70	0.00	0.00	0.00	0.50	00:0	800	0.13	00'0	0.13	0.36	00.0	0.36	00.00	98.0	2.30	1.30	American M		not used for	c demonstrati		e to rounding
	Sinusoidal rotational test	Supplemental electrical test	Posturography	Posturography	Posturography	Pure tone hearing test, air	Pure tone audiometry, air	Audiometry, air & bone	Speech threshold audiometry	Speech audiometry, complete	Comprehensive hearing test	Bekesy audiometry, diagnosis	Loudness balance test	Tone decay hearing test	Sisi hearing test	Stenger test, pure tone	Тупрапошету	Acoustic refl threshold tst	Acoustic reflex decay test	Filtered speech hearing test	Staggered spondaic word test	Sensorineural acuity test	Synthetic sentence test	Stenger test, speech	Visual audiometry (vra)	Conditioning play audiometry	Select picture audiometry	Electrocochleography	Auditor evoke potent, compre	Auditor evoke potent, compre	Auditor evoke potent, compre	Evoked auditory test	Evoked auditory test	Evoked auditory test	Evoked auditory test	Evoked auditory test	Evoked auditory test	Ear protector evaluation	Oral speech device eval	Cochlear implt f'up exam < 7	Reprogram cochlear implt < 7	CPT codes and descriptions only are copyright 2009 American M	Reserved.	it values are removed to codes not payable by incurrency, prease established as a courtesy to the general public and are not used for	The budget neutrality reduction from the chiropractic demonstrat	41, and 90942. The required reduct	Global totals for malpractice RVUs may not sum due to rounding
į	Status A	4	٧	٧	∢	z	∢	Κ	٧	4	٧	¥	K	Ą	٧	¥	¥	٧	٧	4	٧	∢	¥	₹	∢	Ą	¥	< -	∢	< <	τ <	: ∢	V	ĸ	<	٧	∢	∢	٧	٧	¥	des and	į.	ed as a c.	dget neur	codes 98940, 9894 Medicare nayment.	totals for
;	M 0 d			<u>1</u> C	56) 1C	07		TC	56		1C	56					¹ CPT cc	Reserved.	establish	The bu	codes 92 Medican	Global
CPT ^{1.3} 7	HCPCS 92546																																											_			

	Global	XX	X	XXX	XXX	XXX	XXX	XX	XX	XXX	XXX	XXX	XXX	XXX	XX	XXX	XXX	XX	XXX	XXX	XXX	XX	XXX	? }	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	YYY	X		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	XXX	\$ \$ \$	XXX	200	XXX							
₩ a-	RVUs.3.	0.03	0.00	00:0	0.03	0.01	00.0	10.0	0.03	00.0	0.03	0.04	0.00	0.04	0.05	0.00	0.05	0.04	00'0	0.04	0.05	0.00	0.05	0.0	90.0	0.03	0.00	0.03	0.02	0.00	0.02	0.02	0.00	0.02	0.02	0.00	70.0	000	0.00	500	100	0.00	pts		cen	/Us for CPT	for		
Facility	RVU*	0.58	NA	ΝĄ	0.17	NA	NA	60.0	ď	NA V	0.22	Y X	NA	0.26	NA	NA	0.31	NA	NA	0.29	Ϋ́Z	V.	0.36	K 4	0.47	Y V	N A	81.0	Y V	NA VA	0.1	Y :	AN S	0.10	Y Z	¥ .	C V	NA N	76.0	07.0 V V	<u> </u>	ď Z	on. All Rig	7	attles bave o	ed in the RV	e files used		
Non- Facility	RVUs.3	0.58	0.21	4.59	0.17	0.52	0.43	60.0	0.62	0.40	0.22	0.71	0.45	0.26	0.83	0.52	0.31	0.74	0.46	0.29	68.0	0.53	0.36	CU:1	0.40	0.53	0.36	0.18	0.42	15.0	0.11	0.51	0.34	0.10	0.51	0.30	5.5	0.44	36.0	0.70		0.26	cal Associati	+	that mese v	is not reflect	effected in the		
Physi-	RVUs ^{2,3}	0.52	0.00	0.00	0.52	0.25	00.0	0.25	9.65	0.00	9.00	0.77	0.00	0.77	06'0	0.00	0.90	0.85	0.00	0.85	1.05	0.00	1.05	C7:1	36.00	55.0	000	0.52	0.30	0.00	0.30	0.45	0.00	0.45	0.43	0.00	0.43	00.0	0.00	0.78	7.0	9.0	serican Medi	-	e, piease nou used for Me	monstration	will only be r		rounding.
	Description	ECG record/review	ECG recording	Ecg/monitoring and analysis	Ecg/review, interpret only	ECG/signal-averaged	ECG/signal-averaged	ECG/signal-averaged	Pm device progreeval, sngl	Pm device progreeval, sngl	Pm device progr eval, sngl	Pm device progr eval, dual	Pm device progreeval, dual	Pm device progr eval, dual	Pm device progr eval, multi	Pm device progr eval, multi	Pm device progr eval, multi	led device prog eval, 1 sngl	Icd device prog eval, 1 sngl	led device prog eval, I sngl	led device progr eval, dual	Icd device progr eval, dual	led device progreval, dual	icd device progr eval, muit	tod device progressed, munt	It device eval most	Ilr device eval progr	Ilr device eval progr	Pre-op pm device eval	Pre-op pm device eval	Pre-op pm device eval	Pre-op icd device eval	Pre-op icd device eval	Pre-op icd device eval	Pm device eval in person	rm device eval in person	rm device eval in person	Tod device interpolate	ica device mierrogate	lea device interrogate	וכוח מכייוני כיימו	lem device eval	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that mess values have been sortablished as a contract to the nament multipound are not used for Medicare natural.	istablished as a countest to the general proof, and are not used for inscincare payment. The budget neutrality reduction from the chiromactic demonstration is not reflected in the RVUs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	of.	Global fotals for majoractice K VUS may not sum due to rounding.
	Startus	٧	Ą	٧	4	¥	¥	٧	٧	K	¥	¥	¥	4	<	٧	4	٧	4	٧	¥	¥	∢ .	< -	۲ -	< ∢	<	4	٧	4	¥.	∢	< -	∢	₹ -	₹ .	< -	۲ -	₹ •	< <	۲ .	∢	codes and	E	ues are ref	udget neul	8940,989	Medicare payment	il fotais ioi
	Mod						IC	56		TC	56		IC	56		IC	56		C	56		JC	56	Ę	ץ נ	9	TC	26		C	26		JC :	56	Ę	: ئے	97	Ţ	۲ ;	07	6	2	CPT	Reserved	it val	3 The b	codes	Medica	CIOR
, Company	HCPCS	93268	93270	93271	93272	93278	93278	93278	93279	93279	93279	93280	93280	93280	93281	93281	93281	93282	93282	93282	93283	93283	93283	43284	+07CK	93766	93285	93285	93286	93286	93286	93287	93287	93287	93288	93288	93788	93269	93269	68756	06766	93290							
Wal-																																			0.00 XXX					0000						for CPT			
	RVUs ^{2,3,4}	0.57	0.15	1.22	1.19	0.92	0.00	0.00	0.62	0.17	19'0	0.31	10.0	0.00	10.0	0.00	0.03	0.04	0.02	0.00	10.0	90:0	0.00	0.06	0.0	0.00	10'0	0.00	10'0	0.03	0.00	0.00	0.03	0.03	0.00	0.03	0.00	0.00	0.02	0.00	0.00	0.02	All Rights	,	s have been	the R VUs for CPT	les used for		
Facility	RVUs ^{2,3} RVUs ^{2,3,4}	3.84 0.57	1.00 0.15	10.06 1.22	10.36 1.19	8.40 0.92	0.00 0.00	0.00 0.00	4.21 0.62	1.09 0.17	4.16 0.61	2.00 0.31	0.28 0.01	NA 0.00	0.00	NA 0.00	0.18 0.03	1.39 0.04	0.15 0.02	NA 0.00	0.10 0.01	NA 0.06	NA 0.00	0.40 0.06	NA 0.04	0.00	0.17 0.01	NA 0.00	0.04 0.01	1,45 0.03	NA 0.00	NA 0.00	0.21 0.03	0.19 0.03	NA 0.00	1.35 0.03	NA 0.00	0.00 er e	0.18 0.02	0.00	NA 0.00		sociation. All Rights	,	hese values have been	payment. reflected in the RVUs for CPT	ed in the files used for		
Non- Facility Facility	RVUs ^{2,3} RVUs ^{2,3,4}	NA 3.84 0.57	1.00 0.15	10.06 1.22	10.36 1.19	8.40 0.92	0.00 0.00	0.00 0.00	4.21 0.62	1.09 0.17	4.16 0.61	2.00 0.31	0.28 0.01	0.00	0.00	NA 0.00	0.03	1.39 0.04	0.15 0.02	NA 0.00	0.10 0.01	NA 0.06	NA 0.00	0.40 0.06	0.0	0.00	0.17 0.01	NA 0.00	0.04 0.01	1.45 0.03	NA 0.00	NA 0.00	0.21 0.03	0.19 0.03	0.00	1.35 0.03	NA 0.00	0.00 er e	0.18 0.02	0.00	NA 0.00	0.02	1edical Association. All Rights		note that these values have been	Medicare payment.	be reflected in the files used for		ań.
Non- Facility Facility	RVUs ^{2,3} RVUs ^{2,3,4}	NA 3.84 0.57	1.00 0.15	NA 10.06 1.22	NA 10.36 1.19	NA 8.40 0.92	0.00 0.00 0.00	0.00 0.00 0.00	NA 4.21 0.62	NA 1.09 0.17	NA 4.16 0.61	NA 2.00 0.31	0.28 0.28 0.01	0.22 NA 0.00	0.00	NA 0.00	0.18 0.18 0.03	1.39 0.04	0.15 0.15 0.02	1.13 NA 0.00	0.10 0.10 0.01	1.71 NA 0.06	NA 0.00	0.40 0.40 0.06	NA 0.04	000 AN 600	0.17 0.01	0.13 NA 0.00	0.04 0.04 0.01	1.45 1.45 0.03	0.63 NA 0.00	0.89 NA 0.00	0.21 0.21 0.03	0.19 0.19 0.03	0.00 NA 0.00	1.35 1.35 0.03	0.55 NA 0.00	0.00 AN 40.10	0.18 0.18	0.00 0.00	0000 NA 0000	0.02	American Medical Association. All Rights		icare, please note that these values have been	not used for Medicare payment. c demonstration is not reflected in the R VIJs for CPT	ion will only be reflected in the files used for		e to rounding.
Non- Facility Facility	RVUs ^{2,3} RVUs ^{2,3,4}	a 10.96 NA 3.84 0.57	Coronary artery dilation 2.97 NA 1.00 0.15	22.70 NA 10.06 1.22	Revision of mitral valve 23.48 NA 10.36 1.19	Revision of pulmonary valve 18.12 NA 8.40 0.92	Revision of heart chamber 0.00 0.00 0.00 0.00	0.00 0.00 0.00	Coronary atherectomy [2.07 NA 4.21 0.62	Coronary atherectomy add on 3.26 NA 1.09 0.17	Pul art balloon repr. percut 11.98 NA 4.16 0.51	Pul art balloon repr. percut 5.99 NA 2.00 0.31	Electrocardiogram, complete 0.17 0.28 0.28 0.01	0,00 0.22 NA 0.00	Electrocardiogram report 0.17 0.06 0.06 0.01	Transmission of ecg 0.00 3.60 NA 0.00	Report on transmitted ecg 0.52 0.18 0.18 0.03	0.75 1.39 1.39 0.04	Cardiovascular stress test 0.45 0.15 0.15 0.02	Cardiovascular stress test 0.00 1.13 NA 0.00	Cardiovascular stress lest 0.30 0.10 0.10 0.01	Cardiac drug stress test 1.17 1.71 NA 0.06	Cardiac drug stress test 0.00 1.31 NA 0.00	Cardiac drug stress test 1.17 0.40 0.40 0.06	0.75 3.22 NA 0.04	Microvoli 1-waye assess 0.00 2.97 NA 0.00	Physhm ECG with renort 0.16 0.17 0.37 0.01	Rhythm ECG, tracing 0.00 0.13 NA 0.00	0.16 0.04 0.04 0.01	24 hrs 0.52 1.45 1.45 0.03	0.00 0.63 NA 0.00	0.89 NA 0.00	0.52 0.21 0.21 0.03	0.52 0.19 0.19 0.03	Remote 30 day ecg tech supp 0.00 0.00 NA 0.00	ECG monitor/report, 24 hrs 0.52 1.55 1.55 0.03	0.00 0.55 NA 0.00	ECG monitor/report, 24 hrs 0.00 1.04 INA 0.00	0.52 0.18 0.02	ECG monitor/report, 24 hrs 0.00 0.00 0.00 0.00	0.00 NA 0.00	0.15 0.15 0.02	odes and descriptions only are copyright 2009 American Medical Association. All Rights		ies are reflected for codes not payable by Medicare, please note that these values have been	thed as a courtesy to the general public and are not used for Medicare payment. I door nountable reduction from the chiromactic demonstration is not reflected in the RVIJs for CPT	1980, 98941, and 98942. The required reduction will only be reflected in the files used for	re payment.	l totals for malpractice R V Us may not sum due to rounding.
Non- Facility Facility	Work PE Fraction RVUs ²³ RVUs ^{23,4}	A Coronary artery dilation 10.96 NA 3.84 0.57	Coronary artery dilation 2.97 NA 1.00 0.15	Revision of aortic valve 22.70 NA 10.06 1.22	Revision of mitral valve 23.48 NA 10.36 1.19	Revision of pulmonary valve 18.12 NA 8.40 0.92	Revision of heart chamber 0.00 0.00 0.00 0.00	Revision of heart chamber 0.00 0.00 0.00 0.00	Coronary atherectomy [2.07 NA 4.21 0.62	Coronary atherectomy add on 3.26 NA 1.09 0.17	Pul art balloon repr. percut 11.98 NA 4.16 0.51	Pul art balloon repr. percut 5.99 NA 2.00 0.31	Electrocardiogram, complete 0.17 0.28 0.28 0.01	Electrocardiogram, tracing 0.00 0.22 NA 0.00	Electrocardiogram report 0.17 0.06 0.06 0.01	Transmission of ecg 0.00 3.60 NA 0.00	Report on transmitted ecg 0.52 0.18 0.18 0.03	Cardiovascular stress test 0.75 1.39 1.39 0.04	Cardiovascular stress test 0.45 0.15 0.15 0.02	Cardiovascular stress test 0.00 1.13 NA 0.00	Cardiovascular stress lest 0.30 0.10 0.10 0.01	Cardiac drug stress test 1.17 1.71 NA 0.06	Cardiac drug stress test 0.00 1.31 NA 0.00	A Cardiac drug stress test 1.17 0.40 0.40 0.06	A Microvolt t-wave assess 0.75 5.22 INA 0.04	Microvoli 1-waye assess 0.00 2.97 NA 0.00	A Phythm EGG with report 0.16 0.17 0.17 0.01	Rhythm ECG, tracing 0.00 0.13 NA 0.00	0.16 0.04 0.04 0.01	ECG monitor/report, 24 hrs 0.52 1.45 1.45 0.03	ECG monitor/record, 24 hrs 0.00 0.63 NA 0.00	ECG monitor/report, 24 hrs 0.00 0.89 NA 0.00	0.52 0.21 0.21 0.03	Remote 30 day ecg rev/report 0.52 0.19 0.19 0.03	Remote 30 day ecg tech supp 0.00 0.00 NA 0.00	ECG monitor/report, 24 hrs 0.52 1.55 1.55 0.03	Ecg monitor/record, 24 hrs 0.00 0.55 NA 0.00	ECG monitor/report, 24 hrs 0.00 1.04 INA 0.00	ECG monitor/review, 24 hrs 0.52 0.18 0.02	ECG monitor/report, 24 hrs 0.00 0.00 0.00 0.00	ECG monitor/report, 24 hrs 0.00 0.00 NA 0.00	0.45 0.15 0.15 0.02	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	Reserved.	² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for Medicare payment. The hidger neutrality reduction from the chirographic demonstration is not reflected in the RVIJs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment.	⁴ Global totals for malpractice RVUs may not sum due to rounding.

CPT ^{C3} /				Physi- cian Work	Non- Facility PE	Facility	Mark Practice		CPI ¹³				Physi- clan Work	Non- Facility PE	Facility PE	Mai- Practice	
HCPCS	Mod	Status	-	RVUs ^{2,3}	RVUs.3	RVUs.	RVUs 23.4	Global	HCPCS	W od	Status	Description	RVUs.23	RVUs ²³	RVUs ^{2,3}	RVUs ^{2 x 4}	Global
06766	97	< -	icin device eval	24.0	0.10	0.10	20:0	X X	73317	į	ر ر	Echo uansesopnageal	0.00	V V	ζ × 12	0.00	X X
16766	Ç	٠.	in device men ogate	0.43	0.40	ć ;	20.0	¥ X X	11006	2 ;	. ر	reno dansesophiageal	0.00	100	2 0	0.0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
16756	۲ ا	< <	Tr device mercogate	0.00	51.0	AN 0	0.00	Y	93317	97	۲ (Echo uansesopnageai	6.0	0.00	000	0.19	ζ ? ?
16266	07	< -	ill device interlogate	5.0	0.10	6.10	2000	V X X	91516	Ç	ر ر	Echo nausesopnageai muaop	0.00	K - 2	× 7	0.00	< >
26756	Ţ	< <	Wed device interrogate	5.0	6.0	V V	70.0	YYY	93318	۲ کر	- د	Echo transcsophageal intraop	0.00	NA 0.49	W. 0	0.00	X X
93292	7 7	۲ -	Wed device interrogate	20.0	6.0	4 N	0.00	×××	01110	97	< <	Pourles are copiagear muaop	020	0.09	0.00	5.00	777
73797	27	< -	wed device interrogate	5.5	0.13	C. 13	70.0	× × ×	93320	ç	< -	Loppier echo exam, near	0.38	57.1	67.1	0.02	777
66766	ç	ξ -	rui piione r-surp device evat	75.0	5 5	Y 2	70.0	Y	93320	۲ کر	ζ •	Doppler echo exam, near	0.00	01.10	2.10	0.00	222
66766	١	< -	Fin phone r-strip device eval	0.00	0.91	K :	0.00	XXX	95320	97	< ∙	Doppier echo exam, heart	0.38	0.13	0.13	0.02	777
93293	56	∀ '	Pm phone r-strip device eval	0.32	0.11	0.11	0.02	XXX	93321	4	V.	Doppler echo exam, heart	0.15	0.45	0.45	0.01	222
93294		٧	Pm device interrogate remote	0.65	0.22	0.22	0.03	XXX	93321	ပ္	Κ.	Doppler echo exam, heart	0.00	0.40	0.40	0.00	222
93295		∢ .	led device interrogat remote		0.40	0.40	90.0	XXX	93321	56	∢ .	Doppler echo exam, heart	0.15	0.05	0.05	0.01	222
93296		٧	Par/icd remote tech serv	0.00	0.72	V.	0.00	XXX	93325		∢	Doppler color flow add-on	0.07	0.50	0.50	0.00	222
93297		<	Icm device interrogat remote	0.52	0.19	0.19	0.03	XXX	93325	TC	۷	Doppler color flow add-on	0.00	0.47	0.47	0.00	777
93298		V	Ifr device interrogat remote	0.52	0.18	0.18	0.03	XXX	93325	76	٧	Doppler color flow add-on	0.07	0.05	0.02	0.00	777
93299		ပ	Icm/ilr remote tech serv	0.00	0.00	ΝĄ	0.00	XXX	93350		¥	Stress tte only	1.46	3.68	NA	0.07	XXX
93303		Ą	Echo transthoracic	1.30	3.62	ΥV	90:0	XXX	93350	TC	¥	Stress tte only	00.0	3.18	ĄN	00.0	XXX
93303	TC	٧	Echo transthoracic	0.00	3.18	ΝĄ	00:0	XXX	93350	56	K,	Stress tte only	1.46	0.50	0.50	0.07	XXX
93303	26	٧	Echo transthoracic	1.30	4.0	0.44	90.0	XXX	93351		٧	Stress tte complete	1.75	4.18	NA	60'0	XXX
93304		¥	Echo transthoracic	0.75	2.52	NA	0.04	XXX	93351	JC	٨	Stress tte complete	0.00	3.59	NA	91.0	XXX
93304	TC	٧	Echo transthoracic	0.00	2.27	NA	0.00	XXX	93351	26	<	Stress tte complete	1.75	0.59	NA	90.0	XXX
93304	56	٧	Echo transthoracic	0.75	0.25	0.25	0.04	XXX	93352		4	Admin ecg contrast agent	0.19	0.63	NA	10.0	222
93306		∢	Tte w/doppler, complete	1,30	2.94	NA	0.07	XXX	93501		٧	Right heart catheterization	3.02	11.37	ΝA	0.16	000
93306	JC	٧	Tte w/doppler, complete	0.00	2.49	NA	0.00	XXX	93501	1C	¥	Right heart catheterization	0.00	10.36	Ϋ́	0.01	000
93306	56	Ą	Tte w/doppler, complete	1.30	0.44	0,44	90.0	XXX	93501	56	٧	Right heart catheterization	3.02	10.1	10.1	0.15	000
93307		A	Tte w/o doppler, complete	0.92	2.76	NA	0.05	XXX	93503		٧	Insert/place heart catheter	2.91	A'N	NA	61.0	000
93307	10	٧	Tte w/o doppler, complete	0.00	2.45	NA	00:0	XXX	93505		¥	Biopsy of heart lining	4.37	11.06	NA	0.32	000
93307	36	Ą	Tte w/o doppler, complete	0.92	0.31	0.31	0.04	XXX	93505	C	٧	Biopsy of heart lining	0.00	9.58	Ν	10.0	000
93308		٧	Tte, f-up or lmtd	0.53	1.90	NA	0.03	XXX	93505	56	K	Biopsy of heart lining	4.37	1.47	1.47	0.31	000
93308	TC	٧	Tte, f-up or lmtd	0.00	1.72	NA	0.00	XXX	93508		٧	Cath placement, angiography	4.09	15.55	NA	0.21	000
93308	56	٧	Tte, f-up or lmtd	0.53	0.18	0.18	0.03	XXX	93508	70	٧	Cath placement, angiography	0.00	14.17	NA	0.01	000
93312		∢	Echo transesophageal	2.20	5.72	ΥN	0.11	XXX	93508	70	4	Cath placement, angiography	4.09	1.37	1.37	0.20	000
93312	JC	∢	Echo transesophageal	0.00	5.05	Ϋ́	10.0	XXX	93510		<	Left heart catheterization	4.32	15.24	NA	0.22	000
93312	56	∢	Echo transesophageal	2.20	99.0	99'0	0.11	XXX	01586	JC	٧	Left heart catheterization	0.00	13.79	NA	0.01	000
93313		٧	Echo transesophageal	0.95	NA	0.17	90.0	XXX	93510	56	٧	Left heart catheterization	4.32	1.45	1.45	0.21	000
93314		٧	Echo transesophageal	1.25	5.82	NA	90.0	XXX	93511		ပ	Left heart catheterization	0.00	NA	NA	0.00	000
93314	2	∢	Echo transesophageal	0.00	5.42	NA	0.00	XXX	93511	IC	ပ	Left heart catheterization	0.00	Ϋ́	NA	0.00	000
93314	56	<	Echo transesophageal	1.25	0.40	0.40	90'0	XXX	93511	56	4	Left heart catheterization	5.02	1.68	1.68	0.26	000
		U	Echo transesophageal	0.00	NA	ΝA	00'0	XXX	93514		ပ	Left heart catheterization	0.00	ΝA	NA	0.00	000
	TC	O	Echo transesophageal	0.00	NA	NA	000	XXX	93514	ည	ပ	Left heart catheterization	0.00	NA	NA	0.00	000
	56	٨	Echo transesophageal	2.78	0.89	68.0	0.17	XXX	93514	56	Ą	Left heart catheterization	7.04	2.36	2.36	0.36	000
93316		٧	Echo transesophageal	0.95	NA	0.22	0.05	XXX	93524		C	Left heart catheterization	0.00	ΝA	NA	0.00	000
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ac.	Reserved	÷								Reserved	i						
	It value	es are re	It values are reflected for codes not payable by Medicare, please note that these values have been	e, piease not	e that these v	alues have	xen			It value	s are reti	If values are reflected for codes not payable by Medicare, please note that these values have been	re, please note	that these va	ilues have be	EJ	
ย่	The but	dget neu	estabished as a courtest to the general public and are not used for reference. The budget neutrality reduction from the chiropractic demonstration is not i	used for ivit	is not reflected	ed in the R	payment. reflected in the RVUs for CPT			The bus	dget neun	istatuated as a courtesy to me general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	t used for Me emonstration	ocare payme is not reflecte	nt. d in the RVI	Js for CPT	
ŭ Z	odes 98	codes 98940, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare marment	will only be	reflected in t	he files usec	. tor			codes 98	codes 98940, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare narment	will only be r	eflected in th	e files used 1	je	
٠.,-`	Global	totals fo	Global totals for maloractice RVUs may not sum due to rounding.	rounding.		•				Global	totals for	Global totals for materactice R VI is may not sum due to rounding.	rounding				
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Reserved.

It values are reflected for codes not payable by Medicare, please note that these values have been stablished as a countersy to the general public and are not used for Medicare payment.

The budgen enutrality reduction from the chropractic demostrations is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

CPT ⁽³⁾	:	;		Physi- cian Work	Non- Facility PE	Facility	Mal- Practice		CPTF				Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice	į
HCPCS 0.7570	Mod	Status	Electronburiology evaluation	900	SOA Z	900	#0.00 X	OUU	01777	DOM	Starus	Diethysmocraphy report	6VUS	80 A	80 O	100	XXX
93026	Ç	ی د	Electrophysiology evaluation	00.0	C 52	90.0	000	000	77.60		: <	Andrea magazine action	80 7	2 30	7.30	92.0	9
02056	, ×	ه (Electrophysiology evaluation	22	00 %	3.00	0.00	900	03774	Ţ	< ⊲	Analyze pacemaker system	000	0.63	690	100	8 8
02007	3	ر ز	Electronhysiology evaluation	30	NA N	8 8	000	222	03774	, ×	: 4	Analyze pacemaker system	88	1 67	1.67	0.24	8 8
12027	J.) C	Cleanable in comments of the c	000	V.V	00.0	000	222	03740	2	; α	Tannamires andient etidies	92.0	2	V V	100	XXX
12056	2, 5) 4	Electrophysiciosy evaluation	2.10	0.71	0.71	0.0	222	93740	TC	2 00	Temperature oradient studies	0.00	X X	. X	0.00	XXX
63622	ì	٠	Electrophysiology evaluation	000	N Z	000	000	222	93740	36	α.	Temperature gradient studies	0.16	90.0	0.06	0.01	XXX
22006	TC	ن د	Electrophysiology evaluation	000	Z Z	000	0.00	777	93745	2	a C	Set-up cardiovert-defibrill	0.00	000	8 Z	0.00	XXX
27074	2 %	> د	Electrophysically evaluation	3 10	101	20:0	2000	777	03745	T) ر	Set up cardiovert-defibrill	00.0	0.00	2	000	XXX
27056	3	د د	Stimulation racing heart	0.10	t V	000	000	777	03745	2 %	י נ	Set-in cardiovert-defibril	00.0	000	000	000	XXX
03631	Ţ	ی ر	Stummation, pacing near	90.0	< 4 Z Z	9 6	800	777	03770	07	מנ	Measure venous massure	0.00	0.0 VA	3 ×	000	XXX
02027	7 %	- د	Stimulation pacing treat	2.85	900	90.0	0.00	777	07770	TC	α	Measure venous pressure	2 0	Z Z	. 2	000	XXX
02053	97	< (Simulation, pacing near	000	0.30 NA	000	000	000	07754	2 %	o or	Measure venous pressure	0.00	90	200	0.00	X X X
470C6	10	ر د	Electrophysiologic study	0.00	C Z	000	900	000	93784	3	2 <	Ambulatory BP monitoring	0.38	0.97	0.97	000	XXX
7000	2 %	> 4	Electronhysiologic study	4.80	9	1.60	0.26	000	91786		. 4	Ambulatory BP recording	000	0.72	A Z	000	XXX
11910	3	<i>ر</i> د	Heart pacino marmino	8	2	000	000	000	93788		: «	Ambulatory BP analysis	0.00	040	Y.	000	XXX
15950	Ţ	ے د	Heart pacing manning	000	Y X	000	000	000	93790		: ∢	Review/report BP recording	0.38	0.14	0.14	0.02	XXX
12920	2 %) 4	Heart nacine marning	7.59	7.41	7.41	1.19	000	93797		: ∢	Cardiac rehah	0.18	0.27	0.07	0.01	000
0.000	24	ر ر	Evaluation bear device	000	N V	Ϋ́	000	000	03798		; ∢	Cardiac rehab/monitor	0.28	0.35	0.10	100	8 8
04920	J.	ی ر	Evaluation heart device	000	V V	Y Z	000	000	03700		: 0	Cardiovascular procedure	00.0	000	Y Z	000	XXX
02640	2 4	- د	Evaluation heart device	20.00		2 -	0.00	000	93789	T) د	Cardiovascular procedure	00.0	000	. 4	00:0	XXX
93040	97	< (Evaluation near device	5.0	01.7 VIV	01.1 V M	270	900	03700	2 %) ر	Cardiovascular procedure	8.5	0000	200	000	X X X
93041	ú	ی ر	Electrophysiology evaluation	00.0	t v	V V	000	990	93,739	2	ه د	Calculorascular procedure Extraoranial childr	0.00	2.42	8 N	0.01	XXX
93041	۲,	- د	riccinophysiology evaluation	200	6	50	0.33	000	37976	Ç	ς <	Extracornical study	900	3 2.4	2	0.00	X X X
93041	97	< <	Electrophysiology evaluation	7.67	66.7	66.4	75.0	000	93613	ک لا	< <	Extracranial study	0.00	4. O	800	0.00	XXX
93042	ç	٠ -	Electrophysiology evaluation	90.4			170	200	03000	9	۲ -	The action of the design of th	770	999	00:0	200	222
93642	2 5	∢ +	Electrophysiology evaluation	00:0	3.34	3.34	0.01	000	93880	7	< <	Extracranial study	0.00	2.49	£ 2	000	X X
75047	07	< -	A block have duration form	00,4	G V	57.1	0.55	000	03880	3,4	(<	Extraction of the control of the con	09:0	02.0	000	0.00	XXX
05056		< <	Ablate heart distribution focus	16.23	K 4 2	5.46	0.86	000	93660	07	< ⊲	Extracranial study	0.60	4.05	NA NA	80.0	XXX
15056		< -	Ablate hand durchigher focus	17.65	V V	90.5	000	900	03883	T.	: ∢	Extracranial study	000	3 63	. A	000	XXX
75056		< 4	Tilt table avaluation	68.1	70,	20.0	010	000	79966	3,4	< ∢	Extracranial study	0.40	2.75	<u> </u>	0.05	XXX
09910	Ţ	< <	Tilt table evaluation	000	1.47	C\$ -	000	000	93886	3	: ∢	Intracranial study	94	8.06	Y Z	90'0	XXX
03660	2 5	4 ×	Tilt table evaluation	1.89	49.0	0.64	0.10	000	93886	JC	. «	Intracranial study	000	17.7	N. A.	0.00	X
93662	i	: O	Intracardiac ecg (ice)	00.0	NA	0.00	0.00	222	93886	56	¥	Intracranial study	0.94	0.35	0.35	90.0	XXX
93662	TC	ပ	Intracardiac ecg (ice)	0.00	Ϋ́Z	0.00	00.0	222	93888		٧	Intracranial study	0.62	4.99	٧	0.05	XXX
93662	56	V	Intracardiac ecg (ice)	2.80	0.94	0.94	0.15	777	93888	1C	ĸ	Intracranial study	0.00	4.76	NA	0.00	XXX
89986		Z	Peripheral vascular rehab	0.00	4.0	Š	0.00	XXX	93888	56	V	Intracranial study	0.62	0.22	0.22	0.05	XXX
93701		V	Bioimpedance, thoracic	0.17	0.63	Ϋ́	0.01	XXX	63860		Ą	Tcd, vasoreactivity study	1.00	16'9	NA A	90.0	XXX
93701	TC	∢	Bioimpedance, thoracic	0.00	0.57	N'A	0.00	XXX	93890	IC	٧	Tcd, vasoreactivity study	0.00	6.54	Y Y	00.0	XXX
93701	56	٧	Bioimpedance, thoracic	0.17	90:0	90.0	0.01	xxx	93890	56	٧	Tcd, vasoreactivity study	1.00	0.37	0.37	50.0	XXX
93720		∢	Total body plethysmography	0.17	=	=	0.01	XXX	93892		V	Tcd, emboli detect w/o mj	1.15	00.6	ΨZ	0.07	XXX
93721		٧	Plethysmography tracing	0.00	0.97	N A	0.00	XXX	93892	2.	V	Tcd, emboli detect w/o inj	0.00	8.56	Y Y	0.00	XX
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	Reserved.	ğ.	Reserved. 2 15 units and mellioned for modern not moughly by Madionne polesses note that t	Mane anota	e that thece	hace unfine have been				Reserved	1. Se are refi	keserved. If as inse see reflected for codes not noushla by Madicara places note that these us inse hour boon	ton escelar esca	that thece w	hiec house by	10	
	establis	hed as a c	stablished as a courtesy to the general public and are not used for Medicare	used for Me	dicare payment	values may e	1000			establish	ed as a co	established as a courtesy to the general public and are not used for Medicare payment	not used for Me	dicare payme	ant.	3	
	The bu	udget net	The budget neutrality reduction from the chiropractic demonstration is not i	monstration	is not reflec	ted in the R	reflected in the RVUs for CPT			The bu	dget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflect	ed in the RV	Js for CPT	
	codes 9	8640, 98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be I	reflected in	the files use	1 for			sodes 98	940, 989	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	on will only be r	eflected in th	e files used	or	
	Medica	Medicare payment.	Medicare payment.							4 Global	Medicare payment.	occident payment. Clobal totals for malorastica DVI is may not sum due to soundian	ouipunos es				
	0.00	II (ULATA II	of marpractice is 103 findy for such our to	omining.								marginaries es em son sum que	Something.				

CPT ¹³ /				Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice		CPT ^{1,3} /				Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice	
HCPCS	Wod	Status	Description	RVUs.	RVUs.	RVUs.	RVUs.	Global	HCPCS	Wor	Status	Description	RVUs".	KVUs.	#AN#	MAC#	Global
93892	70	< ∙	1cd, emboli detect w/o inj	51.1	± ;	4.4	00.0	X	93978	97	< <	Vascular study	0.00	3,60	Y N	900	XXX
75893	1	€ .	ica, embou defect willi	0.00	15.0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0.0	VVV	61666	ç	٠.	Vascular study	000	33.6		000	***
93893	2 %	< <	Ted semboli detect w/mj	0.00	0.44	NA 0	0.00	XXX	93979	ې د	٤4	Vascular study Vascular study	96.0	0.14	0.14	0.04	XXX
93922	04	< <	Extremity study	0.25	2.91	N.	0.02	XXX	93980	2	· 4	Penile vascular study	1.25	3.03	NA A	60.0	XXX
93922	C	<	Extremity study	0.00	2.82	NA	0.00	XXX	93980	C	¥	Penile vascular study	0.00	2.62	NA NA	00:0	XXX
93922	56	<	Extremity study	0.25	80.0	80.0	0.02	XXX	93980	97	Ą	Penile vascular study	1.25	0.41	0.41	60:0	XXX
93923		٧	Extremity study	0.45	4,36	Ν	0.05	XXX	18656		Ą	Penile vascular study	0.44	2.35	NA	0.03	XXX
93923	TC	٧	Extremity study	0.00	4.21	NA	0.00	xxx	18686	IC	4	Penile vascular study	0.00	2.21	N.	00.0	XXX
93923	56	∢	Extremity study	0.45	0.14	0.14	0.05	XXX	18686	56	٧	Penile vascular study	0.44	0.14	0.14	0.03	XXX
93924		4	Extremity study	0.50	5.35	Y Z	0.05	XXX	93982		×	Aneurysm pressure sens study	0.30	08.0	NA V	0.05	XXX
93924	70	٧	Extremity study	0.00	5.19	NA V	0.00	XXX	93990		٨	Doppler flow testing	0.25	5.25	NA	0.04	XXX
93924	97	Ą	Extremity study	0.50	0.16	91.0	0.05	XXX	06666	C	¥	Doppler flow testing	0.00	5.17	NA NA	0.00	XXX
93925		٧	Lower extremity study	0.58	7.18	NA NA	0.05	XXX	93990	56	¥	Doppler flow testing	0.25	0.08	0.08	0.04	XXX
93925	TC	¥	Lower extremity study	0.00	66'9	Ν	0.00	XXX	94002		4	Vent mgmt inpat, init day	1.99	Y Z	0.46	0.12	XXX
93925	56	ď	Lower extremity study	0.58	0.19	0.19	0.05	XXX	94003		¥	Vent right inpat, subq day	1.37	Ϋ́Z	0.40	80.0	XXX
93926		K	Lower extremity study	0.39	4.75	NA	90.0	XXX	94004		¥	Vent ingmt of per day	1.00	Ϋ́	0.29	90.0	XXX
93926	70	K	Lower extremity study	0.00	4.64	Ϋ́	00.0	XXX	94005		œ	Home vent mgmt supervision	1.50	0.93	NA	80.0	XXX
93926	56	Ą	Lower extremity study	0.39	0.12	0.12	90.0	XXX	94010		*	Breathing capacity test	0.17	0.71	NA	10.0	XXX
93930		K	Upper extremity study	0.46	5.75	NA	0.04	XXX	94010	C	¥	Breathing capacity test	0.00	99.0	N'A	0.00	XXX
93930	10	4	Upper extremity study	0.00	5.60	NA A	00.0	XXX	94010	56	٧	Breathing capacity test	0.17	90.0	90'0	10.0	XXX
93930	76	Æ	Upper extremity study	0.46	0.15	0.15	0.04	XXX	94014		٧	Patient recorded spirometry	0.52	0.74	0.74	0.03	XXX
93931		¥	Upper extremity study	0.31	3.80	Ϋ́	0.03	XXX	94015		Ą	Patient recorded spirometry	0.00	0.58	NA	0.00	XXX
93931	C	¥	Upper extremity study	0.00	3.70	Ν	0.00	XXX	94016		¥	Review patient spirometry	0.52	0.17	0.17	0.02	XXX
93931	56	∢	Upper extremity study	0.31	0.10	0.10	0.03	XXX	94060		∢	Evaluation of wheezing	0.31	1.22	1.22	0.02	XXX
93965		Ą	Extremity study	0.35	2.73	Y.	0.03	XXX	94060	10	∢	Evaluation of wheezing	0.00	1.12	1.12	0.00	XX
93965	IC	4	Extremity study	0.00	2.62	Ν	0.00	XXX	94060	56	٧	Evaluation of wheezing	0.31	0.10	0.10	0.02	XXX
63965	56	ď	Extremity study	0.35	0.11	0.1	0.03	XXX	94070		¥	Evaluation of wheezing	0.60	0.95	₹ Z	0.03	XXX
93970		٧	Extremity study	89.0	5.69	NA VA	0.07	XXX	94070	70	¥	Evaluation of wheezing	0.00	0.76	Y.	0.00	XXX
93970	IC	ď	Extremity study	0.00	5.48	Z	0.00	XXX	94070	56	∢	Evaluation of wheezing	09.0	0.19	0.19	0.03	XXX
93970	56	¥	Extremity study	89.0	0.21	0.21	0.07	XXX	94150		æ	Vital capacity test	0.07	0.53	ΑN	0.00	XX
93971		∢	Extremity study	0.45	3.68	Ϋ́	0.05	XXX	94150	TC	m.	Vital capacity test	0.00	0.50	Y .	0.00	XXX
93971	70	¥	Extremity study	0.00	3.55	¥.	0.00	XXX	94150	56	φ.	Vital capacity test	0.07	0.03	0.03	0.00	XXX
93971	56	A	Extremity study	0.45	0.14	0.14	0.05	XXX	94200	į	∢ .	Lung function test (MBC/MVV)	0.11	0.49	¥;	0.01	XXX
93975		∀ .	Vascular study	08.1	7.49	ď:	0.16	XXX	94200	2 ;	< ∙	Lung function test (MBC/MVV)	3.5	0.43	NA 600	0.00	X X
93975	2	V	Vascular study	0.00	6.92	۲ : د	0.01	YXX	94200	97	₹ -	Lung runction test (MBC/MVV)	1 6	0.03	60.0	0.0	\$ \$
93975	56	∢	Vascular study	08.1	0.57	0.57	0.15	XXX	94240	É	∢ •	Residual lung capacity	97.0	0.73	Z :	10.0	X
93976		¥	Vascular study	17.1	4.08	Y :	0.10	777	04746	; ي	< ∙	Residual lung capacity	0.00	0.00	V. 0	9.00	5
93976	JC 1	∢ -	Vascular study	0.00	3.70	Y S	000	XXX	94240	97	< <	Residual lung capacity	97.0	0.08	0.08	0.0	X X
93976	97	ď	Vascular study	17:1	0.37	0.57	0.09	YYY	0.746	i		Expued gas conection	1.5	0.40	V :	0.00	\$
93978		V	Vascular study	9.0	5.38	V.	0.07	XXX	94250	ဥ	₹ .	Expired gas collection	0.00	0.45	NA S	0.00	XXX
93978	C	K	Vascular study	0.00	5.17	Š	0.00	XXX	94250	92 .	٧	Expired gas collection	0.11	0.03	0.03	0.01	XX
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	Reserved	ed.		-	5	1				Reserved	i i	keserved.	1	that there a	alternation of the		
	If value	ues are re	If values are reflected for codes not payable by Medicare, please note that these values have been	e, piease noto	dioem naver	atues nave i				it valu	es are rer	it values are reflected for codes not payable by includer; prease note had mad mess variableholders a contract to the nemeral public and are not used for Medicare natural	re, prease not	dicare naum	aines nave o	100	
	The h.	indicat ner	estabusined as a countesy to the general phone and are not used for includate payment. The findows neutralist reduction from the chizometic demonstration is not reflected in the RVI is for CPT.	used for rate	incare payment is not reflected	out.	71s for CPT			The h	deet neul	standard as a council to me general public and are not used to a secretar payment. The hudget neutrality reduction from the chiopractic demonstration is not reflected in the RVUs for CPT.	emonstration	is not reflect	ed in the RV	Us for CPT	
	codes 9:	Muget ac	the bringer treatmenty reduction from the campbractic echiasmustrian is not reflected in the files used for	will only be 1	reflected in t	be files used	for constant			codes 9	8940,989	odes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in th	re files used	Grant	
	Medica	Medicare payment.	ent.	•						Medica	Medicare payment.						
	4 Globa	I totals fo	Global totals for malpractice RVUs may not sum due to rounding	rounding.						4 Globa	totals for	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.				

Nearway are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

*Global totals for malpractice RVUs may not sum due to rounding.

I fivalues are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget returnity reduction from the chiropractic demonstration is not reflected in the R.VUs for CPT codes 99940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice R.VUs may not sum due to rounding.

CPT ^{1,2} /				Physi- cian Work	Non- Facility PE	Facility PE	Mat- Practice		les LdO		,		Physi- cian Work	Non- Facility PE	Facility PE	Mat. Practice	
HCPCS	N od	Status	Description	RVUs	RVU8-	YACS	KVU#	Global	SOCIO	Mod	Status	Description	RVUs.	KVU8"	EVUS.	KVUs.	Giobai
05050		< ⊲	Andrew patch test	00:0	71.0	V V	90.0	XXX	80850	<u> </u>	< ⊲	Polysomnography, 1-3	2,65	100	100	0.0	XXX
95050		: «	Photosensitivity tests	000	50.	NA	000	XXX	05810	2	: ∢	Polysomnography 4 or more	3.52	16.27	X X	61.0	XXX
09056		· «	Eye allergy tests	0.00	0.80	0.80	0.00	XXX	95810	TC	: <	Polysonnography, 4 or more	0.00	15.13	Ϋ́	10.0	XX
92065		4	Nose allergy test	0.00	19.0	0.61	0.00	XXX	01856	56	٧	Polysomnography, 4 or more	3.52	1.13	1.13	0.18	XXX
95070		Ą	Bronchial allergy tests	0.00	69.0	N A	0.00	XXX	11856		Ą	Polysomnography w/cpap	3.79	18:01	NA	0.21	XXX
95071		¥	Bronchial allergy tests	0.00	0.85	NA	0.00	XXX	95811	7C	٧	Polysomnography w/cpap	0.00	16.80	ΝA	10.0	XXX
95075		Ą	Ingestion challenge test	0.95	0.75	0.35	0.03	XXX	11856	56	¥	Polysomnography w/cpap	3.79	1.21	1.21	0.20	XXX
95115		¥	Immunotherapy, one injection	0.00	0.22	NA	0.00	XXX	95812		A	Eeg, 41-60 minutes	1.08	8.58	N A	90:0	XXX
95117		٧	Immunotherapy injections	0.00	0.26	Ν	0.00	XXX	95812	TC	K	Eeg, 41-60 minutes	00'0	8.14	NA	0.00	XXX
95120		_	Immunotherapy, one injection	0.00	0.00	0.00	0.00	XXX	95812	79	Ą	Eeg, 41-60 minutes	1.08	0.43	0.43	90.0	XXX
95125		_	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	XXX	61856		K	Eeg, over 1 hour	1.73	9.22	NA A	0.10	XXX
95130			Immunotherapy, insect venom	000	0.00	0.00	0.00	XXX	61856	TC	¥	Eeg, over 1 hour	0.00	8.52	NA	0.00	XXX
95131		_	Immunotherapy, insect venoms	0.00	0.00	00'0	0.00	XXX	95813	56	Ą	Eeg, over 1 hour	1.73	69.0	69'0	0.10	XXX
95132		_	Immunotherapy, insect venous	0.00	0.00	0.00	000	XXX	91856		<	Eeg, awake and drowsy	1.08	1.77	ΥN	0.07	XXX
95133		~	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	95816	TC	٧	Eeg, awake and drowsy	0.00	7.34	NA NA	00.0	XXX
95134		_	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX	92816	56	<	Eeg, awake and drowsy	1.08	0.43	0.43	90'0	XXX
95144		¥	Antigen therapy services	90.0	0.25	0.02	0.00	XXX	61856		∢	Eeg, awake and asleep	1.08	10'6	NA A	90.0	XX
95145		٧	Antigen therapy services	90.0	0.32	0.02	0.00	XXX	61856	TC	٧	Eeg, awake and asleep	0.00	8.57	NA A	0.00	XXX
95146		Ą	Antigen therapy services	90.0	09.0	0.02	00'0	XXX	61856	56	٧	Eeg, awake and asleep	1.08	0.43	0.43	90:0	XXX
95147		V	Antigen therapy services	90.0	0.59	0.02	0.00	XXX	95822		Ą	Eeg, coma or sleep only	1.08	8.10	NA	90:0	XXX
95148		∢	Antigen therapy services	90.0	0.87	0.02	00.0	XXX	95822	TC	٧	Eeg, coma or sleep only	0.00	7.66	N A	0.00	XXX
95149		4	Antigen therapy services	90.0	1.16	0.02	0.00	XXX	95822	56	٧	Eeg, coma or sleep only	1.08	0.44	0.44	90.0	XX
95165		∢	Antigen therapy services	90.0	0.26	0.02	0.00	XXX	95824		ပ	Eeg, cerebral death only	0.00	Ϋ́	N A	0.00	XXX
95170		4	Antigen therapy services	90.0	0.18	0.02	0.00	XXX	95824	۲ ا	O	Eeg, cerebral death only	0.00	Y.	A A	0.00	XXX
95180		∢	Rapid desensitization	2.01	1.62	0.83	90.0	XXX	95824	76	4	Eeg, cerebral death only	0.74	0.29	0.29	0.05	XX
66156		ပ	Allergy immunology services	0.00	0.00	0.00	0.00	XXX	95827		¥.	Eeg, all night recording	1.08	17.56	Y.	0.07	XXX
95250		∢ .	Glucose monitoring, cont	0.00	3.63	AN.	0.00	XXX	95827	ည :	₹.	Eeg, all night recording	00'0	17.13	Y.	0.00	XX
95251		∢ !	Gluc monitor, cont, phys i&r	0.85	0.35	0.35	0.04	XXX	95827	56	۷.	Eeg, all night recording	1.08	0.43	0.43	90:0	XXX
95803		ပ (Actigraphy testing	0:00	0.00	V.	0.00	XXX	95829	ŧ	۲,	Surgery electrocorticogram	6.20	36.81	¥.	0.27	X
95803	<u>ن</u> ک	ပ (Actigraphy testing	0.00	0.00	4 S	000	XXX	67856	2 %	< ∙	Surgery electrocordicogram	0.00	34.27	α ,	70.0	XXX
50050	97	. ر	Actigraphy testing	0.00	0.00	00.0	0.00	X X X	67856	97	₹ <	Surgery electroconicogram	07.0	4.04	4.34	07.0	X X X
50866	Ć,	< ₹	Multiple steep latency test	88.	64.0	2 2	0.10	Y X X	95830		< <	line minds totals	0.70	78.0	0.00	1.0	<u> </u>
5005	ץ נ	< 4	Multiple steep fateury test	88.	0.00	190	010	XXX	05832		(⊲	Line muscle testing, manual	0.20	0.30	110	70.0	XXX
92806	ì	: ∢	Sleep study, unattended	991	3.81	N N	60'0	XXX	95833		: <	Body muscle testing, manual	0.47	0.51	0.13	100	XXX
95806	TC	<	Sleen study, unattended	0.00	3.25	N.	00:0	XXX	95834		*	Body muscle testing, manual	090	0.67	0.20	0.02	XXX
92806	56	<	Sleep study, unattended	99'1	0.56	0.56	80.0	XXX	95851		<	Range of motion measurements	0.16	0.31	0.05	0.01	XXX
95807		¥	Sleep study, attended	1.66	9.76	NA	60:0	XXX	95852		Ą	Range of motion measurements	0.11	0.29	0.04	10.0	XXX
95807	TC	Ą	Sleep study, attended	0.00	9,23	NA	0.00	XXX	95857		4	Tensilon test	0.53	08.0	0.24	0.03	XXX
95807	56	¥	Sleep study, attended	1.66	0.52	0.52	80.0	XXX	09856		Ą	Muscle test, one limb	96.0	1.58	NA	0.05	XXX
80856		4	Polysomnography, 1-3	2.65	16.69	NA	0.13	XXX	09856	7	¥	Muscle test, one limb	0.00	1.16	Ϋ́	0.00	XXX
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⊣ e	Reserved.	d.	Reserved. I found not explosived for nodes not mountly by Madinate Inferes note that these values have been	afone a note	y about that	d avec have	100			Reserved.	. ore refle	Reserved, If volume are reflected for ande and requirible by Madiane alsoca ands that these values have been	ston ascala av	that there yo	does how he	5	
J	stablish	ed as a cc	ourtesy to the general public and are not	used for Mec	dicare payme	ent.				establish	ed as a co	established as a courtesy to the general public and are not used for Medicare payment	ot used for Me	ficare payme	III.	ŝ	
	The buc	dget neut	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	monstration	is not reflect	ted in the R\	'Us for CPT			The buc	lget neutr	The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	lemonstration	is not reflecte	d in the RV	Js for CPT	
	codes 98	codes 98940, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Madiona maximum.	will only be r	reflected in t	ne tiles used	101			Medicare	Medicare payment	codes y8940, 98941, and 98942. The required reduction will only be retlected in the files used for Medicare navment	ı wili only be r	eflected un th	e files used	č	
. •	Global	totals for	Global totals for malpractice RVUs may not sum due to rounding	rounding						4 Global 1	otals for	Global totals for malpractice RVUs may not sum due to rounding	o rounding.				
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CPT ¹³ /				Physi- cian Work	Non- Facility PE	Facility	Mai- Practice		CPT ^{C3}	;		:	Physi- clan Work	Non- Facility PE	Facility PE	Mal- Practice	
HCPCS	Pog ?	Status	Description	KVUs	KVU	EVUS.	KAUS.	Global	SOLON OCCUPANT OF THE PROPERTY	DOM:	Status	Description	KVUs.	KVUS	KAU8	KAUS	agois >
95800	07	۲.	Muscle test, one mus	0.90	2.42	7 7 7	0,0	VVV	93900	07	۲ -	Motor derve conduction test	0.42	0.19	0.10	0.02	ξ λ
93801	Ç E	۲.	Muscle test, 2 mios	† 6	C7-7	<u> </u>	90.0	VYV	93903	Ç	۲ -	MODEL HELVE CONDUCTION IEST	0.00	1.00	C <	000	< >>
9580	2 ;	∢ .	Muscle test, 2 umbs	0.00	1.5.	V C	0.00	YYY	92903	<u> </u>	₹ -	Motor nerve conduction test	0.00	0.00	£ 2	0.00	4 2 3 3 3 3 3 3 3 3 3 3
95861	9	< ∙	Muscle test, 2 limbs	1.34	0.00	0.0	80.0	X XX	95903	97	∢ <	Motor nerve conduction lest	0.00	47.0	47.0 N.A	0.03	444
95503	Ş	₹ •	Muscle lest, 5 limbs	1.0/	17.7	ζ.;	0.0	V X X	93904	(۲.	Sease nerve conduction lest	0.34	71.1	C :	20.0	\$ 3
95863	2	Æ	Muscle test, 3 lumbs	0.00	1.93	Z.	0.0	XXX	95904	2	¥	Sense nerve conduction test	00.0	86.0	¢	0.00	XXX
95863	56	٧	Muscle test, 3 limbs	1.87	0.78	0.78	0.10	XXX	92804	56	¥	Sense nerve conduction test	0.34	0.14	0.14	0.02	XX
95864		4	Muscle test, 4 limbs	1.99	2.90	AN	0.11	XXX	95920		٧	Intraop nerve test add-on	2.11	2.30	2.30	0.12	777
95864	C	∢	Muscle test, 4 limbs	00:00	2.07	ΝΑ	0.01	XXX	95920	TC	٧	Intraop nerve test add-on	0.00	4.1	1.44	0.01	222
95864	56	Ą	Muscle test, 4 limbs	1.99	0.83	0.83	0.10	XXX	95920	76	٧	Intraop nerve test add-on	2.11	98.0	98.0	0.11	222
95865		Ą	Muscle test, larynx	1.57	1.70	NA	0.07	XXX	95921		٧	Autonomic nerv function test	06.0	1.29	N A	0.04	XXX
95865	7	ď	Muscle test, larynx	00.0	1.00	A'Z	0.00	XXX	95921	TC	٧	Autonomic nerv function test	00.0	96.0	NA	0.00	XXX
95865	56	¥	Muscle test, larynx	1.57	0.70	0.70	0.07	XXX	95921	26	4	Autonomic nerv function test	0.00	0.33	0.33	0.04	XXX
95866		4	Muscle test, hemidiaphragm	1.25	1.76	ΑN	80:0	XXX	95922		¥	Autonomic nerv function test	96.0	1.79	NA	0.05	XXX
95866	10	¥.	Muscle test, hemidiaphragm	00:0	1.26	Ϋ́Z	0.00	XXX	95922	TC	Ą	Autonomic nerv function test	0.00	1.43	Ϋ́	00'0	XXX
95866	56	V	Muscle test, hemidiaphragm	1.25	0.50	0.50	0.07	XXX	95922	26	¥	Autonomic nery function test	96:0	0.36	0.36	0.04	XXX
65867		∢	Muscle test cran nerv unilat	0.79	1.50	NA	0.04	XXX	95923		<	Autonomic nerv function test	0.00	3.30	A.	0.05	XXX
95867	TC	Ą	Muscle test cran nerv unilat	00.0	1.16	NA	00.0	XXX	95923	TC	K	Autonomic nerv function test	0.00	2.95	NA	0.00	XXX
95867	56	Ą	Muscle test cran nerv unilat	0.79	0.34	0.34	0.04	XXX	95923	56	¥	Autonomic nery function test	0.00	0.36	0.36	0.05	XXX
89856		¥	Muscle test cran nerve bilat	1.18	1.91	ΥN	90:0	XXX	95925		∢	Somatosensory testing	0.54	4.19	NA	0.03	XXX
89856	IC	٧	Muscle test cran nerve bilat	0.00	1.42	NA A	0.00	XXX	95925	IC	V	Somatosensory testing	0.00	3.97	NA	0.00	XXX
89856	56	٧	Muscle test cran nerve bilat	1.18	0.50	0.50	90'0	XXX	95925	56	4	Somatosensory testing	0.54	0.22	0.22	0.03	XXX
69856		Ą	Muscle test, thor paraspinal	0.37	1.45	NA	0.02	XXX	92656		٧	Somatosensory testing	0.54	4.04	ΥZ	0.03	XXX
69856	TC	٧	Muscle test, thor paraspinal	0.00	1,29	ΝA	0.00	XXX	92656	22	¥	Somatosensory testing	0.00	3.83	N.	0.00	XXX
69856	97	٧	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	XXX	92656	26	۷	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95870		٧	Muscle test, nonparaspinal	0.37	1.39	NA	0.02	XXX	95927		K	Somatosensory testing	0.54	3,44	NA	0.03	XXX
95870	TC	Ą	Muscle test, nonparaspinal	00'0	1.23	NA	0.00	XXX	95927	IC	<	Somatosensory testing	0.00	3.22	NA	0.00	XXX
95870	97	٧	Muscle test, nonparaspinal	0,37	0.16	0.16	0.02	XXX	95927	56	V	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95872		¥	Muscle test, one fiber	2.88	2.22	N A	91.0	XXX	95928		٧	C motor evoked, uppr limbs	1.50	5.48	NA	60.0	XXX
95872	TC.	¥	Muscle test, one fiber	0.00	1.05	ΥN	0.01	XXX	92656	Ω	¥	C motor evoked, uppr limbs	0.00	4.87	NA	0.00	XXX
95872	56	¥	Muscle test, one fiber	2.88	1.17	1.17	91.0	XXX	95928	26	٧	C motor evoked, uppr limbs	1.50	0.61	0.61	60.0	XXX
95873		¥	Guide nery destr, elec stim	0.37	1.39	1.39	0.01	222	95929		4	C motor evoked, lwr limbs	1.50	5.92	V Z	60.0	XXX
95873	TC	٧	Guide nery destr, elec stim	00:00	121	1.21	00.0	ZZZ	62656	JC	<	C motor evoked, lwr limbs	0.00	5.31	NA	0.00	XXX
95873	56	¥	Guide nerv destr, elec stim	0.37	0.18	0.18	0.01	222	62656	56	¥	C motor evoked, Iwr limbs	1.50	0.61	0.61	60'0	XXX
95874		Ą	Guide nerv destr, needle emg	0.37	1.31	1.31	0.02	777	95930		<	Visual evoked potential test	0.35	3.51	NA	0.02	XXX
95874	TC.	K	Guide nerv destr, needle eng	00.0	1.15	1.15	00:0	222	95930	10	K	Visual evoked potential test	0.00	3.36	ΝA	0.00	XXX
95874	56	∢	Guide nerv destr, needle emg	0.37	0.16	0.16	0.02	222	95930	56	4	Visual evoked potential test	0.35	0.15	0.15	20'0	XX
95875		٧	Limb exercise test	1.10	16.1	NA	0.07	XXX	95933		¥	Blink reflex test	0.59	1.60	NA	0.03	XXX
95875	C	¥	Limb exercise test	0.00	1.47	AA	00.0	XXX	95933	70	4	Blink reflex test	00.0	1.36	NA	0.00	XXX
95875	26	¥	Limb exercise test	1.10	4.0	0.44	90:0	XXX	95933	56	¥	Blink reflex test	0.59	0.24	0.24	0.03	XXX
		<	Motor nerve conduction test	0.42	1.24	NA A	0.02	XXX	95934		4	H-reflex test	0.51	1.15	NA	0.03	XXX
95900	TC	¥	Motor nerve conduction test	0.00	90'1	NA A	000	XXX	95934	JC	¥	H-reflex test	0.00	0.93	NA	0.00	XXX
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24	Reserved	÷	•				,			Reserved	ij.						

Reserved.

It values are reflected for codes not payable by Medicare, please note that these values have been established as a councesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget nearthiny reduction from the chiropractic demonstration is not reflected in the R VUs for CPT codes 989401, 38041, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Medicare payment.

Global totals for malpractice R VUs may not sum due to rounding.

1,111				Physi- cian Work	Non- Facility PE	Facility PE	Mai. Practice		CPT ⁽²⁾				Physi- cian Work	Non- Facility PE	Facility	Mal- Practice	
HCPCS	Mod	Status	Description	RVUs ^{2,3}	RVUs.3	RVUs ^{2,3}	RVUs ^{2,3,4}	Global	HCPCS	_	Startus	Description	RVUs.	RVUs.	RVUs"	KVUs".	Global
95934	56	K	H-reflex test	0.51	0.21	0.21	0.03	XXX	93966	97	< (Meg, evoked, single	9.98	1.0	5 V	1000	777
95936		*	H-reflex test	0.55	0.17	ď.	0.03	XXX	19666	ě	، د	Meg, evoked, each adden	0.00	90.0	V 12	00.0	777
92636	17	4	H-reflex test	0.00	0.55	NA S	0.00	XXX	19666	2 2	. د	Meg, evoked, each add/El	3.40	9.7	141	0.00	777
92636	56	K	H-reflex test	0.55	0.22	77.0	0.03	XXX	95961	07	ζ.	vieg, evokeu, each aduzi	0.45	1 23	81.0	100	XXX
95937	Ç	K 4	Neuromuscular junction test	0.65	/1.1	€ Z	0.00	XXX	95970		< ∢	Analyze neurostim, no prog Analyze neurostim, simple	0.78	0.68	0.27	0.05	XXX
95937	۽ ڍ	Κ •	Neuromascular junction lest	0.00	0.76	92.0	000	XXX	95972		: ∢	Analyze neurostim, complex	1.50	1.32	0.57	0.12	XXX
15656	07	< <	Ambulaton, see monitoring	15.	2.10	NA N	60.0	XXX	95973		: 4	Analyze neurostim, complex	0.92	0.72	0.37	0.07	777
05050	ŗ.	(⊲	Ambulatory ees monitoring	000	6.50	×	000	XXX	95974		4	Cranial neurostim, complex	3.00	2.08	1.15	0.19	XXX
05050	2 %	< <	Ambulatory eep monitoring	1.51	0.60	09:0	0.08	XXX	95975		Ą	Cranial neurostim, complex	1.70	1.02	99.0	0.10	777
95951	3	: U	EEG monitoring/videorecord	0.00	NA	NA A	0.00	XXX	92656		4	Analyze neurostim brain/łh	3.50	2.65	1.45	0.29	XXX
95951	70	Ü	EEG monitoring/videorecord	0.00	N.	NA	0.00	XXX	95979		¥	Analyz neurostim brain addon	1.64	1.07	0.68	0.11	777
95951	26	<	EEG monitoring/videorecord	5.99	2.41	2.41	0.37	XXX	08656		٧	Io anal gast n-stim init	0.80	Y :	0.34	0.13	XX
95953		Ą	EEG monitoring/computer	3.30	10.69	NA	0.20	XXX	95981		4	Io anal gast n-stim subsq	0.30	0.51	0.17	0.03	XX
95953	TC	∢	EEG monitoring/computer	0.00	9.36	NA	10:0	XXX	95982		٧	Io ga n-stim subsq w/reprog	9.65	69.0	0.31	90.0	XXX
95953	26	. <	EEG monitoring/computer	3.30	1.33	1.33	0.19	XXX	95990		4	Spin/brain pump refil & main	0.00	2.17	Ϋ́	0.00	XXX
95954	i	. 4	EEG monitoring/giving drugs	2.45	6.35	N.A	0.15	XXX	16656		4	Spin/brain pump refil & main	0.77	2.24	0.29	0.05	XXX
95954	TC	. <	EEG monitoring/giving drugs	0.00	2.67	NA	0.01	XXX	98992		_	Canalith repositioning proc	0.75	0.39	0.27	0.04	XXX
95954	56	. ∢	EEG monitoring/giving drugs	2.45	29.0	0.67	0.14	XXX	66656		ပ	Neurological procedure	0.00	00'0	0.00	00.0	XXX
55656	<u>.</u>	. ⋖	EEG during surgery	1.01	3.87	3.87	90.0	XXX	00096		4	Motion analysis, video/3d	1.80	Y.	0.71	60'0	XXX
95955	21	: ∢	EEG during surgery	00.00	3.47	3.47	00.0	XXX	10096		4	Motion test w/ft press meas	2.15	NA	0.76	0.10	XXX
95955	56	. ≺	EEG during surgery	1.01	0.40	0.40	90:0	XXX	96002		٧	Dynamic surface emg	0.41	NA	0.15	0.02	XXX
95956		<	Eeg monitoring, cable/radio	3.08	18.79	NA	0.18	XXX	60096		<	Dynamic fine wire emg	0.37	Y Z	0.15	0.02	XX
95956	TC	∢	Eeg monitoring, cable/radio	00.0	17.61	NA	0.01	XXX	96004		4	Phys review of motion tests	2.14	0.88	0.88	0.11	XX
95956	56	٧	Eeg monitoring, cable/radio	3.08	1.18	1.18	0.18	XXX	02096		ပ	Functional brain mapping	0.00	ΝA	Y.	0.00	XX
95957		¥	EEG digital analysis	1.98	8.38	NA	0.12	XXX	96020	IC	ပ	Functional brain mapping	0.00	Y.	Y	0.00	XX
95957	TC	Ą	EEG digital analysis	0.00	7.60	NA	0.01	XXX	96020	56	¥	Functional brain mapping	3.43	<u>8</u>	7 7 7	0.25	XXX
95957	56	¥	EEG digital analysis	86.1	0.79	0.79	0.12	XXX	96040		В	Genetic counseling, 30 min	0.00	1.07	Y	0.00	XXX
85656		¥	EEG monitoring/function test	4.24	9.18	N.	0.26	XXX	10196		4	Psycho testing by psych/phys	1.86	0.24	0.23	0.06	X
95958	TC	¥	EEG monitoring/function test	0.00	7.57	NA A	0.01	XXX	96102		۷.	Psycho testing by technician	0.50	0.99	0.10	0.03	XXX
85656	56	Κ	EEG monitoring/function test	4.24	19.1	1.61	0.24	XXX	96103		< ⋅	Psycho testing admin by comp	0.51	71.1	0.10	20:0	777
19656		¥	Electrode stimulation, brain	2.97	4.28	Ν	81.0	XXX	96105		∢.	Assessment of appasia	0.00	2.51	ζ.	0.00	X X X X X X X X X X
19656	77	¥	Electrode stimulation, brain	0.00	3.06	¥.	10.0	XXX	96110		۷.	Developmental test, tim	0.00	0.20	K. 0	0.00	3
98961	56	¥	Electrode stimulation, brain	2.97	1.23	1.23	0.17	XXX	1196		₹ •	Developmental lest, extend	2.00	1.02	0.00	71.0	< >
98962	í	۷.	Electrode stim, brain add-on	3.21	3.18	3.18	61.0	777	96116		∢∢	Neuropeach tet by nevehinhos	98.1	0.58	0.40	0.05	XX
95962	⊇ ;	∢ .	Electrode sum, brain add-on	0.00	66.	00.7	0.00	777	01106		: ⊲	Neuropsych tat by payon payon Neuropsych testing by tec	0.55	61	0.07	0.02	XXX
79656	97	۲ د	Man montaneous	3.21	000	S V	0.00	XXX	96120		: ≺	Neuropsych ist admin w/comp	0.51	8.	0.14	0.02	XXX
59050	J.	ی د	Mea spontaneous	000	00.0	Ϋ́	000	XXX	96125		<	Cognitive test by hc pro	1.70	<u>-</u> 25	0.62	0.05	XXX
59050	2 %	۵ م	Mes spontaneous	7.99	3.23	3.23	0.48	XXX	96150		4	Assess hlth/behave, init	0.50	90:0	0.05	10.0	XXX
95966	Ç.	: ر	Mee. evoked, single	000	0.00	NA A	00'0	XXX	15196		∢	Assess hlth/behave, subseq	0.48	90.0	0.05	0.01	XXX
99656	T	ن ر	Mey eyoked, single	00.00	00.0	NA	0.00	XXX	96152		٧	Intervene hlth/behave, indiv	0.46	90.0	0.05	0.01	XXX
	CPT	sdec and d	PPT codes and descriptions only are conversely American Medical Association. All Rights	nerican Medi	cal Associa	ion. All Ris	hts			CPT coc	les and d	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	merican Medi	ical Associat	ion. All Rig	ats	
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	If value	es are refl	2 If values are reflected for codes not payable by Medicare, please note that these values have been	re, please not	e that these	values have	Seen			· If values	are refle	if values are reflected for codes not payable by Medicare, please note that these values have been contained as a contract to the contact making and are not used for Medicare traument.	re, please note	e that these v	aines have b	een	
	establish The bu	ned as a co deet neuts	established as a courtesy to the general public and are not used for Medicare paymen. ³ The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	t used for Me emoustration	ocare payment is not reflected	ted in the R	/Us for CPT			The bud	get neutr	statusments a commercy to me general poon, and are not research produced in the RVUs for CPT. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT.	lemonstration	is not reflect	ed in the RV	Us for CPT	
,	sodes 98	1940, 989.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be	reflected in	he files used	lfor			codes 98940, 9894	740, 9897 737,779	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Madicina manners.	will only be r	reflected in t	be files used	for	
- 4	Medican	Medicare payment.	Aedicare payment. Clobal totals for malametica DVI is may not sum due to counding	company						Global r	otals for	Global totals for malpractice RVUs may not sum due to rounding.	o rounding.				
	Cicoai	Outra son	illaphacine is vos may not sam sees	. Smorang.									;				

Mal- Practice RVIs ^{2,3,4}	000	800	20.0	0.00	0,00	0.00	0.00	0.04	0.04	0.07	0.00	0.04	0.02	0.05	0.02	00.0	00:0	0.00	0.01	0.01	10.0	0.00	0.01	0.00	0.00	0.00	0.01	10.0	10:0	0.01	0.02	0.00	0.02	0.02	0.01	10:0	10.0	0.00	0.01	10.0	10.0	10.0	10.0	ghts	
Facility PE RVUs ^{2,3}	4 Z	910	0.13	K Z	Y Z	Y.	ΥZ	69.0	69:0	1.27	00.0	٧N	ΝΑ	NA	K.N	0.00	0.00	ΑN	NA	NA	Ϋ́	NA	NA	NA	NA	Z Y	Ϋ́	N A	ΝΆ	ΝA	X	NA	Ν̈́Α	NA	Ν	Ϋ́Z	NA	NA	NA	NA	ΝĀ	N.A	Z K	ion. All Rig	
Non- Facility PE PVIIa ^{2 3}	0.49	2 2	2 5	1.53	1.70	2.18	3.06	3.24	3,34	4.29	00.0	0.78	0.49	1.01	0.74	0.00	0.00	80.0	0.17	0.22	0.30	0.20	0.40	0.10	0.08	0.10	0.24	0.54	0.25	0.12	0.54	0.00	0.38	0.41	9.0	0.33	0.32	0.00	0.35	0.26	0.46	0.26	0.32	ical Associa	
Physi- cian Work RVII*	500	20.0	4.0	0.00	0.00	0.00	0.00	1.15	1.17	2.10	00.00	1.20	09'0	1.20	09.0	00:00	00.00	90:0	0.25	0.18	0.18	90'0	0.17	90'0	90:0	80.0	0.25	0.26	0.21	0.21	0.28	0.00	0.45	0.45	0,44	0.40	0.35	0.00	0.43	0.27	0.44	0.44	0.44	smerican Med	
Descrivition	Tiberaciolet Keht themes	Cidaviolet ugut merapy	1 nchogram	Whole body photography	Photochemotherapy with UV-B	Photochemotherapy with UV-A	Photochemotherapy, UV-A or B	Laser tx, skin < 250 sq cm	Laser tx, skin 250-500 sq cm	Laser tx, skin > 500 sq cm	Dermatological procedure	Pt evaluation	Pt re-evaluation	Ot evaluation	Ot re-evaluation	Athletic train eval	Athletic train reeval	Hot or cold packs therapy	Mechanical traction therapy	Electric stimulation therapy	Vasopneumatic device therapy	Paraffin bath therapy	Whirlpool therapy	Diathermy eg, microwave	Infrared therapy	Ultraviolet therapy	Electrical stimulation	Electric current therapy	Contrast bath therapy	Ultrasound therapy	Hydrotherapy	Physical therapy treatment	Therapeutic exercises	Neuromuscular reeducation	Aquatic therapy/exercises	Gait training therapy	Massage therapy	Physical medicine procedure	Manual therapy	Group therapeutic procedures	Therapeutic activities	Cognitive skills development	Sensory integration	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	
ā	Status	< 0	10	×	¥	¥	4	4	٧	¥	ပ	٧	4	٧	٧	-	••••	8	¥	_	٧	∢	٧	٧	¥	٧	∢	4	٧	∢	4	၁	٧	4	٧	¥	۷	Ü	<	٧	Ą	٧	٧	odes and	넍
3																																												CPT	Keserved.
(c) LdO	2000	00606	306905	96904	01696	21696	61696	06950	12696	66922	66696	97001	97002	97003	91004	97005	92006	97010	97012	97014	91016	91018	97022	97024	97026	97028	97032	97033	97034	97035	97036	97039	97110	97112	97113	91116	97124	97139	97140	97150	97530	97532	97533		
in a second	Cional	***	XXX	XXX	xxx	222	XXX	222	777	222	XXX	222	777	XXX	XXX	XXX	222	XXX	XXX	XXX	000	000	XXX	222	XXX	777	XXX	777	XXX	XXX	222	XXX	000	000	000	XXX	XXX	XXX	XXX	XXX	XXX	777	ZZZ		
Mal- Practice	900	0.00	0.0	0.02	0.01	00'0	0.01	0.01	0.01	0.01	0.01	0.01	0.00	0.01	0.01	0.01	0.00	0.00	0.01	0.01	0.02	0.03	0.01	0.0	0.01	0.01	0.01	10:0	0.01	10.0	10:0	0.01	0.42	0.13	0.09	0.01	0.01	0.00	0.04	000	00.0	0.14	0.03	ights	
Facility PE	S C	10.0	0.05	91.0	Y.Z	V.	Ϋ́	NA	Y.	NA	N.	N.	AN.	N A	NA	NA	N.	0.00	NA	NA	0.28	0.38	N.	NA	NA	NA	NA	NA	NA	NA NA	NA	NA	1.06	0.93	19'0	NA	NA	NA	0.35	0.00	NA	0.38	0.15	ation. All R	
Non- Facility PE	KVU8-	0.02	0.05	0.16	1.12	0.26	1.43	0.34	0.54	0.28	3.35	0.22	2.22	0.42	0.33	1.09	0.40	00.0	1.48	0.57	48	1.97	2.18	1.17	2.85	0.51	3.19	1.35	2.23	3.59	1.59	3.80	18.75	4.35	2.86	2.76	2.28	0.51	1.99	0.00	3.24	0.38	0.15	dical Associa	
Physi- cian Work	KVUs":	0.10	0.45	0.44	0.17	0.09	0.21	0.18	0.19	0.17	0.21	0.18	0.00	0.17	0.17	0.18	0.10	00.00	0.21	0.19	0.52	0.80	0.24	0.20	0.28	0.19	0.21	0.21	0.17	0.17	0.17	0.17	2.37	2.20	1.53	0.21	0.21	0.04	0.75	0.00	0.00	1.10	0.55	American Me	
•	Description	Intervene fulth/behave, group	Interv hlth/behav, fam w/pt	Interv hith/behav fam no pt	Hydration iv infusion, init	Hydrate iv infusion, add-on	Ther/month/diag iv inf. init	Ther/proph/diag iv inf addon	Tx/nronh/do addl seg iv inf	Ther/diag concurrent inf	Sc ther infusion, up to 1 br	Sc ther infusion, addl hr	Sc ther infusion, reset pump	Ther/proph/diag ini. sc/im	Ther/proph/diag ini. ia	Ther/proph/diag ini, iv push	Tx/mg/dx ini new drug addon	Ther/mon/diag ini/inf proc	Chemo, anti-neonl, su/im	Chemo hormon antineopi sa/im	Chemo intralesional un to 7	Chemo intralesional over 7	Chemo, iv push, snel drug	Chemo, iv push, addl drug	Chemo, iv infusion, 1 hr	Chemo, iv infusion, addl hr	Chemo prolong infuse w/pump	Chemo iv infus each addl seg	Chemo, ia, push tecnique	Chemo ia infusion up to 1 hr	Chemo ia infuse each addl br	Chemotherapy, infusion method	Chemotherapy, intracavitary	Chemotherapy, intracavitary	Chemotherapy, into CNS	Refill/maint, portable pump	Refill/maint pump/resvr syst	Irrig drug delivery device	Chemotherapy injection	Chemotherapy, unspecified	Photodynamic tx. skin	Photodynamic tx, 30 min	Photodynamic tx, addl 15 min	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	
į	Status	¥	¥	Z.	٧	₹	₹	: ∢	: <	: ∢	: ∢	< ▼	: ∢	: <	: <	. ≺	. ≺	٤ د	· <	. ∢	; ∢	< ∢	. 4	: <	< <	< <	: ∢	: ∢	. 4	: <	. ≺	. 4	×	<	. ∢	٧	V	 	. ⋖	; U	<	: ∢	: ∢	odes and (-
	Mod																																											¹ CPT ca	Received
CPT ¹² ,	HCPCS	96153	96154	96155	96360	19896	96365	99896	29636	96368	96369	96370	96373	96372	96373	96374	5/196	0/270	96401	06402	20400	96406	96409	96411	96413	96415	96416	96417	06470	96422	96423	96425	96440	96445	96450	96521	96522	96523	96542	96549	29896	02570	96571		

Reserved.

If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 19840, 19841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

Substances are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

4 Global totals for malpractice RVUs may not sum due to rounding.

	Po	Status	Description	Physician Work RVUs ^{2,3}	Non- Facility PE RVUs ²³	Facility PE RVUs ^{2,3}	Mal- Practice RVUs ^{2,3,4}	Global	po N	Statue	Description	Physical clan Work RVUs ^{2,3}	Non- Facility PE RVUs ²³	Facility PE RVUs ^{2,3}	Mat- Practice RVUs ^{23,4}	Global
Nat. Nat. Nat. Nat. Nat. Nat. Nat. Nat.		∢.	Self care magment training	0.45	0.45	¥ ;	0.01	XXX	99050	an o	Medical services after hrs	0.00	0.00	0.00	0.00	XXX
0.00 XXXX 99053 B Med serv (order) 0.00 0.00 0.00 0.00 0.00 0.00 XXXX 99063 B Med serv (order) 0.00		∢ ∕	Community/work remiegration	0.45	0.34	YZ :	0.01	XXX		10 1	Med serv, eve/wkend/bollday	0.00	0.00	0.00	0.00	XXX
0.00 XXX 99000 B Office centregatory care 0.00 0.00 0.00 0.00 0.04 XXX 99000 B Office centregatory care 0.00		۲,	Wheelchair magment training	0.45	0.33 0.00	ď;	0.01	XXX		.	Med sery 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	XX
Name		× .	work nardening	0.00	00.0	¥ 2 ;	0.00	444		ממ	Med service out of office	0.00	000	90.00	0.00	X
0.00 XXX 99000 B Special supplies 0.00 0.00 0.00 0.00 0.00 0.08 XXX 99000 B Special reports of fermas 0.00 <		ν.	work nardening ado-on	0.00	9.0	¥.	0.00	777		n a	Office emergency care	0.00	0.00	00.00	0.00	444
National Color		< <	Active wound care/20 cm of <	0.58	55.1	4 6	90,0	Y X X	99060	n c	Out of other emerg med serv	0.00	00:00	0.00	00.0	X X
0.08 XXX 99071 B Criment outstand maternal 0.00 0.0		< €	Active wound care > 20 cm	0.80	00.0	5 × 2	0.00	XXX	0/066	n c	Special supplies	0.00	00.00	30.00	00.0	\ \ \ \ \ \ \ \ \ \
0.02 XXX 99003 B Special reports or forms 0.00 0.0		n -	wound(s) care non-selective	00.0	64.0	V.	0.00	Y Y X	1/066	n c	Fattent education materials	0.00	9.0	00.0	000	X X
0.02 XXXX 990800 B Special reports of norms 0.00 0.00 0.00 0.00 0.00 0.2 XXXX 99080 B Collectrowew data from prints 0.00		∢ •	Neg press wound tx, < 50 cm	0.55	6.0	0.13	0.00	XXX	8/066	n	Group bealth education	0.00	0.00	90.0	0.00	YYY
0.02 XXX 99082 C. Unustate physical mines 0.00 <t< td=""><th></th><td>₹ .</td><td>Neg press wound tx, > 50 cm</td><td>0.00</td><td>0.50</td><td>7.7</td><td>0.08</td><td>YYY</td><th>08066</th><td>מ</td><th>Special reports or forms</th><td>0.00</td><td>0.00</td><td>0.00</td><td>0.00</td><td>XXX</td></t<>		₹ .	Neg press wound tx, > 50 cm	0.00	0.50	7.7	0.08	YYY	08066	מ	Special reports or forms	0.00	0.00	0.00	0.00	XXX
0.02 XXX 99990 B Confective/wee data from pt 1.10 0.40 0.00 0.00 0.01 XXX 99910 B Special aussthesia service 0.00 NA 0.00 <th></th> <td>V</td> <td>Physical performance test</td> <td>0.45</td> <td>0.40</td> <td>Š.</td> <td>0.02</td> <td>XXX</td> <th>99082</th> <td>ပ :</td> <th>Unusual physician travel</th> <td>000</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>X</td>		V	Physical performance test	0.45	0.40	Š.	0.02	XXX	99082	ပ :	Unusual physician travel	000	0.00	0.00	0.00	X
0.02 XXX 99091 B Collective vector and into mp pt 1.10 0.40 NA 0.00 0.02 XXX 99106 B Acethesia service 0.00 NA 0.00 0.00 0.02 XXX 99145 B Europeacy ansistes and collection of the collec		∢ .	Assistive technology assess	0.62	0.32	YZ:	0.02	XXX			Computer data analysis	0.00	0.00	0.00	00:00	XX
0.00 XXX 99100 B Special austhesia service 0.00 NA 0.00 0.00 0.00 XXX 99116 B Special austhesia sprocedure 0.00 NA 0.00 0.00 0.00 XXX 99146 B Special austhesia procedure 0.00 NA 0.00 0.00 0.01 XXX 99145 C Mod of by same pbys, 5 yrs 0.00 0.00 NA 0.00 0.01 XXX 99145 C Mod of by same pbys, 5 yrs 0.00 0.00 0.00 0.00 0.03 XXX 99149 C Mod of by same pbys, 5 yrs 0.00 0.00 0.00 0.00 0.03 XXX 99149 C Mod of by same pbys, 5 yrs 0.00		4	Orthotic mgmt and training	0.45	0.51	NA V	0.02	XXX		œ i	Collect/review data from pt	01.1	0.40	YZ.	90:0	XXX
000 XXXX 99116 B Ancestical width pytothermia 0.00 NA 0.00 0.00 002 XXXX 99146 B B Energency ancesthesia 0.00 NA 0.00		₹.	Prosthetic training	0.45	0.39	NA A	0.02	XXX		æ	Special anesthesia service	0.00	Y'Z	000	0.00	ZZZ
0.00 XXXX 99143 B Special anaekhesia procedure 0.00 NA 0.00 0.00 0.02 XXXX 99140 C Mod cs by same pbys, < 5 yrs		٧	C/o for orthotic/prosth use	0.25	0.90	Z Y	0.01	XXX		В	Anesthesia with hypothermia	0.00	٧Z	0.00	00:0	222
0.02 XXXX 99140 B. Eurogency auschitesia 0.00		ပ	Physical medicine procedure	0.00	0.00	0.00	0.00	XXX		æ	Special anesthesia procedure	0.00	ΝΑ	0.00	0.00	222
0.00 XXX 99143 C Mode or by same pbys, 5 yrs 0.00 0.00 NA 0.00 0.01 XXXX 99144 C Mode or by same pbys, 5 yrs 0.00 0.00 0.00 0.00 0.00 0.03 XXXX 99145 C Mode of suff pbys add-on 0.00		A	Medical nutrition, indiv, in	0.53	0.10	0.05	0.02	XXX	99140	æ	Emergency anesthesia	0.00	ΝA	000	00'0	222
0.00 XXX 99144 C Mod cs by same plys, 5 yrs + 0.00 0.00 NA 0.00 0.03 XXX 99145 C Mod cs diff plys 5 yrs + 0.00 0.00 NA 0.00 0.03 XXX 99149 C Mod cs diff plys 5 yrs + 0.00 NA NA 0.00 0.03 XXX 99149 C Mod cs diff plys 5 yrs + 0.00 NA 0.00 0.00 0.04 0.00 99170 A Anogenital estan, child 1.75 1.84 0.70 0.00 0.04 0.00 99174 N Visual acuty screen 0.00 0.06 NA 0.00 0.04 0.00 99174 N Visual acuty screen 0.00 0.05 0.00 0.00 0.04 0.00 99174 N Visual acuty screen 0.00 0.05 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		₹	Med nutrition, indiv, subseq	0.45	0.09	0.04	0.02	XXX	99143	ပ	Mod cs by same phys, < 5 yrs	0.00	0.00	NA	00.0	XXX
90.35 XXX 99145 C Mod ce by sauch play add-on 0.00		٧	Medical nutrition, group	0.25	0.03	0.02	0.01	XXX	99144	ပ	Mod cs by same phys, 5 yrs +	0.00	0.00	NA	00.0	XXX
0.03 XXX 99148 C Mod cs diff plays < 5 yrs 0.00 NA NA 0.00 0.03 XXX 99149 C Mod cs diff plays s yrs 0.00 NA NA 0.00 0.03 2XZ 99150 C Mod cs diff plays s yrs 0.00 NA NA 0.00 0.04 0.00 99173 N Visual acuity s yrs 0.00 0.06 NA 0.00 0.04 0.00 99173 N Cell plays add-on 0.00 0.06 NA 0.00 0.04 0.00 99173 N Cell plays add-on 0.00 0.05 0.00		z	Acupunct w/o stimul 15 min	09'0	0.35	0.22	0.03	XXX	99145	ပ	Mod cs by same phys add-on	0.00	0.00	0.00	00.0	222
Name		z	Acupunct w/o stimul addl 15m	0.50	0.22	0.18	0.03	222	99148	ပ	Mod cs diff phys < 5 yrs	0.00	NA	NA	0.00	XXX
0.00 XXX 99150 C Mode os diff phys add-on 0.00 NA 0.00 0.00 0.00 99170 A Anoeganital exam, child 1.75 1.84 0.70 0.10 0.04 0.00 99173 N Visual acutiv screen 0.00 0.08 NA 0.00 0.04 0.00 99173 N A noeganital exam, child 1.75 1.84 0.70 0.10 0.04 0.00 99173 N A noeganital exam, child 0.00 0.68 NA 0.00 0.05 0.00 99183 A Hodeston of your therapy 2.34 3.13 0.81 0.19 0.01 0.02 0.00 99183 A Regional hypothermia 0.00 1.27 NA 0.00 0.02 0.03 99183 A Regional hypothermia 0.00 1.27 NA 0.00 0.02 0.03 0.03 A Regional hypothermia 0.00 0.01 <t< td=""><th></th><td>z</td><td>Acupunct w/stimul 15 min</td><td>99.0</td><td>0.37</td><td>0.24</td><td>0.03</td><td>XXX</td><th>99149</th><td>ပ</td><th>Mod cs diff phys 5 yrs +</th><td>0.00</td><td>NA</td><td>ΝĄ</td><td>00:0</td><td>XXX</td></t<>		z	Acupunct w/stimul 15 min	99.0	0.37	0.24	0.03	XXX	99149	ပ	Mod cs diff phys 5 yrs +	0.00	NA	ΝĄ	00:0	XXX
0.00 99170 A Anogenital exam, child 1.75 1.84 0.70 0.10 0.04 0.00 99173 N Visual acuity screen 0.00 0.06 NA 0.00 0.04 0.00 99174 N Ocular plouscreening 0.00 0.05 NA 0.00 0.04 0.00 99174 N Induction of Yomiting 0.00 0.57 NA 0.00 0.05 0.00 99183 A Infraction of Yomiting 0.00 0.57 NA 0.00 0.02 0.00 99183 A Infraction of Yomiting 0.00 0.57 NA 0.00 0.02 0.00 99183 A Total body hypothermia 0.00 1.77 NA 0.00 0.02 0.00 0.00 1.35 NA 0.00		z	Acupunct w/stimul addl 15m	0.55	0.27	0.20	0.03	222		ပ	Mod cs diff phys add-on	0.00	Z A	0.00	0.00	ZZZ
0.00 99173 N Visual acuity screen 0.00 0.06 NA 0.00 0.04 0.00 99174 N Ocular photoscreening 0.00 0.68 NA 0.00 0.04 0.00 99175 A Induction of voniting 0.00 0.57 NA 0.00 0.05 0.00 99185 A Ityperbaric oxygen therapy 2.34 3.13 0.81 0.19 0.01 0.00 99185 A Ityperbaric oxygen therapy 2.34 3.13 0.81 0.19 0.02 0.00 99185 A Ityperbaric oxygen therapy 0.30 1.37 NA 0.00 0.02 0.00 0.00 0.00 0.00 1.36 NA 0.00 0.02 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.02 XXX 99203 A Office-outpatient visit, new 1.42 1.33 0.49 0.00 0.03 <		Ą	Osteopathic manipulation	0.45	0.37	0.17	0.02	000		¥	Anogenital exam, child	1.75	1.84	0.70	0.10	000
0.04 0.00 99174 N Ceular photoscreening 0.00 0.68 NA 0.00 0.04 0.00 99175 A Induction of vountining 0.00 0.57 NA 0.00 0.02 0.00 99183 A Hyperbaric orygen therapy 2.34 3.13 NA 0.00 0.01 0.00 99185 A Regional hypothermia 0.00 1.27 NA 0.00 0.02 0.03 99186 A Regional hypothermia 0.00 1.27 NA 0.00 0.02 0.00 99185 A Regional hypothermia 0.00 1.27 NA 0.00 0.02 0.00 0		ď	Osteopathic manipulation	99'0	0.47	0.23	0.03	000		z	Visual acuity screen	0.00	90:0	NA	0.00	XXX
0.04 0.00 99175 A Induction of Youniting 0.00 0.57 NA 0.00 0.05 0.06 99183 A Hyperbaric oxygen thraspy 2.34 3.13 0.81 0.01 0.00 99185 A Regional pytothermia 0.00 1.27 NA 0.00 0.02 0.00 99185 A Total body hypothermia 0.00 1.36 NA 0.00 0.02 0.00 99195 A Total body hypothermia 0.00 1.36 NA 0.00 0.02 xxx 99209 A Office-loupatient visit, new 0.48 0.62 0.21 0.04 0.00 xxx 99203 A Office-loupatient visit, new 0.43 0.88 0.40 0.06 0.03 xxx 99203 A Office-loupatient visit, new 2.43 1.82 1.00 0.16 0.04 xxx 99212 A Office-loupatient visit, new 2.43 1.82 0.03 0.11 0.05 xxx 9921 A Office-loupatient v		4	Osteopathic manipulation	0.87	0.59	0.29	0.04	000		z	Ocular photoscreening	0.00	89.0	NA	00'0	XXX
10		٧	Osteopathic manipulation	1.03	99.0	0.34	0.04	000		Ą	Induction of vomiting	0.00	0.57	ΝA	0.00	XXX
100 100 127 104 100		Ą	Osteopathic manipulation	1.19	0.77	0.41	0.05	000	99183	4	Hyperbaric oxygen therapy	2.34	3.13	0.81	61.0	XXX
10		₹	Chiropractic manipulation	0.45	0.25	0.13	0.01	000	68166	¥	Regional hypothermia	0.00	1.27	NA	0.00	XXX
10,000 1		٧	Chiropractic manipulation	0.65	0.32	0.19	0.02	000	98166	«	Total body hypothermia	0.00	1.36	NA	0.00	XXX
10,000, XXX 99199 C Special service/proc/report 0.00 0.00 0.00 0.00 0.00		₹	Chiropractic manipulation	0.87	0.38	0.25	0.02	000	66166	· ·	Phlebotomy	0.00	2.07	NA	0.00	XXX
National Control Con		z	Chiropractic manipulation	0.40	0.23	0.15	0.02	XXX	66166	 O	Special service/proc/report	0.00	0.00	0.00	0.00	XXX
National Content of the Content of		æ	Self-mgmt educ & train, 1 pt	00.0	0.63	ΥN	00:0	XXX	99201	·	Office/outpatient visit, new	0.48	0.62	0.21	0.04	XXX
National Content of the Content of Conte		83	Self-mgmt educ/train, 2-4 pt	0.00	0.30	ΥN	00:0	XXX	69202	· •	Office/outpatient visit, new	0.93	86.0	0.40	90.0	XXX
National N		Ω	Self-mgmt educ/train, 5-8 pt	00.0	0.22	¥ Z	0.00	XXX	99203	¥	Office/outpatient visit, new	1.42	1.33	0.59	0.11	XXX
National N		z	Hc pro phone call 5-10 min	0.25	0.12	60'0	10.0	XXX	99204	- *	Office/outpatient visit, new	2.43	1.82	1.00	0.16	XXX
10.04 XXX 99211		z	He pro phone call 11-20 min	0.50	0.21	0.18	0.03	XXX	99205	¥	Office/outpatient visit, new	3.17	2.11	1.23	0.21	XXX
1,00 XXX		z	He pro phone call 21-30 min	0.75	0.31	0.27	0.04	XXX	99211	Ą	Office/outpatient visit, est	0.18	0.31	0.07	0.01	XXX
100 XXX 99213		8	Specimen handling	00.0	0.00	0.00	0.00	XXX	99212	· •	Office/outpatient visit, est	0.48	0.62	0.20	0.03	XXX
Oct Color	89	Specimen handling	0.00	0.00	0.00	0.00	XXX	99213	·	Office/outpatient visit, est	0.97	0.89	0.39	0.05	XXX	
Office courpatient visit, est 2.11 1.60 0.82 0.12		В	Device handling	0.00	0.00	0.00	00:0	XXX		-	Office/outpatient visit, est	1.50	1.25	0.58	80.0	XXX
CorCPT		æ	Postop follow-up visit	0.00	0.00	00:0	0.00	XXX			Office/outpatient visit, est	2.11	1.60	0.82	0.12	XXX
for CPT	00	les and	descriptions only are copyright 2009 A	merican Med	tical Associa	tion. All Ri	ghts		_	s and de	escriptions only are copyright 2009 Am	erican Medic	al Associatio	n. All Righ	S	
for CPT	Reserved				4				Reserved	ē			1			
for CPT	Specific	dasa co	decieu for codes not payable by inferne, ourtesy to the general public and are m	are, picase no ot used for Ma	edicare payr	values have neat.	1000		i vaues a established	as a cot	cred for codes not payable by Medicare urlesy to the general public and are not	e, piease note used for Med	inat inese va licare paymer	nues nave oe nt.	6	
	P.	get neut	trality reduction from the chiropractic	lemonstration	is not refle.	cted in the R	VUs for CPT		³ The budge	a neutra	ality reduction from the chiropractic de	monstration	s not reflecte	d in the RVI	Js for CPT	
nalmaratice RVI is may not sum due to roundino	š	40,989	141, and 98942. The required reduction	ı will only be	reflected in	the files use	d for		codes 9894(0,9894	1, and 98942. The required reduction is	will only be ra	effected in the	e files used f	ō.	
	2 -	paymer vale for	at. - malnraction B VI is may not sum due t	o roundino					A Global 10g	ayment.	malmactice RVIIs may not sum due to	rounding				

	XXX																													XXX													rCPT	
- 22	80:0	0.0	ö	0.1	0.3	0.0	0.0	0.0	0.1	0.1	9.0	0.1	0.0	9.0	0.1	0.1	0.1	0.0	0.0	0.0	0.1	0.0	9.0	0.0	0.0	0.1	0.05	2:0	0.0	0.0	0.06	0.0	0.0	0.0	90.0	0.09	0.0	0.0	90:0	0.07	0.07	Rights	ve been RVUs for	ised for
Facility PE RVUs ^{2:3}	0.82	Ϋ́Z	NA NA	ΥZ	Ϋ́	ΥN	NA	NA	Ϋ́	X A	Ν	Ν	NA	N.	Y.	NA	ΝΑ	N.	NA	Z Y	NA	0.67	0.64	69.0	69.0	0.80	0.40	4,0	0.00	0.30	0.40	0.26	0.40	0.63	0.40	0.63	0.40	0.63	0.43	0.50	0.50	tion. All	values hav nent. cted in the	the files u
Non- Facility PE RVUs ²³	0.82	0.45	0.61	1.11	1.47	1.64	0.52	62'0	1.10	1.55	7.70	9.	0.44	0.57	96.0	<u>4</u> .	1.73	0.46	0.67	1.06	4.	0.83	0.80	NA	Z.	0.80	0.40	NA .	0.48	0.32	Y.	AN	0.72	1.01	0.72	1.01	0.72	1.01	1.22	1.28	1.27	edical Associa	ote that these Medicare payr on is not refle	e reflected in
Physi- cian Work RVUs ^{2,3}	1,71	1.01	1.52	2.63	3.46	4.09	1.07	1.72	2.46	3.58	1.25	1.80	10'1	1.52	2.53	3.38	4.09	1.00	1.56	2.33	3.28	1.77	1.77	1.71	1.71	2.10	00.1	07'1	0.63	0.82	1.10	0.72	1.10	1.73	1.10	1.73	1.10	1.73	1.19	1.36	1.36	American M	icare, please n not used for l c demonstration	on will only t
Description	Annual nursing fac assessmnt	Domicil/r-home visit new pat	Domicil/r-home visit est pat	Domicil/r-home visit est pat	Domicil/r-home visit est pat	Domicil/r-home visit est pat	Domicil/r-home care supervis	Domicil/r-home care supervis	Home visit, new patient	Home visit, new patient	Home visit, new patient	Home visit, new patient	Home visit, new patient	Home visit, est patient	Prolonged service, office	Prolonged service, office	Prolonged service, inpatient	Prolonged service, inpatient	Prolonged serv, w/o contact	Prolonged serv, w/o contact	Anticosa mont init	Anticose memt subsec	Team conf w/pat by the pro	Team conf w/o pat by phys	Team conf w/o pat by hc pro	Home health care supervision	Home health care supervision	Hospice care supervision	Hospice care supervision	Nursing fac care supervision	Nursing fac care supervision	Init pm e/m, new pat, inf	Init pm e/m, new pat 1-4 yrs	Prev visit, new, age 5-11	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	reserved. For searched. If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT	codes 88940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. **Clobel totals for malmorized DAI is many and some short consisting.							
Status	∢ ·	V	Y	4	Ą	∢	¥	¥	٧	٧	89	8	∢	٧	¥	¥	٧	¥	Ą	4	<	Ą	¥	¥	V.	m	m >	< a	0 00	00	В	В	В	_	æ	, ,	œ i	æ	Z:	Z	z	codes and	ed. ues are ref shed as a c udget neut	codes 98940, 9894 Medicare payment. Global sotals for n
¥ od																																										CPT	The bud	codes 9 Medica
CPT'3) HCPCS	99318	99324	99325	99326	99327	99328	99334	99335	99336	99337	99339	99340	99341	99342	99343	99344	99345	99347	99348	99349	99350	99354	99355	99356	99357	99358	99359	00566	99364	99366	99367	89866	99374	99375	99377	99378	99379	99380	99381	99382	99383			
Mai- Prestice (VUs ^{2,3,4} Global	• • •		0,11 XXX															0.13 XXX							0.18 XXX		0.05 XXX		023 XXX	000 XXX								0.07 XXX	0.11 XXX		0.07	40	n s for CPT	i _{te}
Facility PE F XVUs ^{2,3} R	0.61	.47	0.80	60.1	0.71	8.	.45	.29	1.52	1.74	66	.27	1.55	191	061	1.23	646	691	2.	.38	36	.55	.83	20	94.	.12	24	* 5	92	Z Z	38	691	.78	90'1	131	0.41	0.64	0.84 4	8 :	0.58	0.73	All Rights	these values have been payment.	les used fo
- - -			NA VA		4							NA AN) VA					98.1								Y S		NA				0.78	vn.	_			-			73	ssociation.	these value e payment. t reflected i	ted in the fi
																																									0.73	Medical A	e note that or Medicar ation is no	y be reflec
Physi- clan Work RVUs ^{2,3}	1.28	1.28	2.14	2.99	1.92	2.61	3.85	0.76	1.39	2,00	2.56	3.41	4.26	1.28	1,90	0.64	1.34	88.	3.02	3.77	1.00	1.50	2.27	3.29	4.00	0.45	0.88	45.7 75.6	3.80	0.00	4.50	2.25	<u>.</u>	2.34	3.06	0.76	1.16	1.55	2.35	1.13	1.50	American	care, pleas not used for demonstr	on will on
Status Description	A Observation care discharge		_	_	_	A Initial hospital care	A Initial hospital care	 A Subsequent hospital care 	A Subsequent hospital care	 Subsequent hospital care 	A Observ/hosp same date	 A Observ/hosp same date 	 A Observ/hosp same date 	 A Hospital discharge day 		N Office consultation	N Office consultation	Ĭ	Ĭ	N Office consultation	N Inpatient consultation	_	_	_				A Emergency dept visit		B Direct advanced life support	A Critical care, first hour	A Critical care, add£130 min	 A Nursing facility care, init 	 A Nursing facility care, init 	 A Nursing facility care, init 	A Nursing fac care, subseq	 A Nursing fac care, subseq 	 A Nursing fac care, subseq 		 A Nursing fac discharge day 	 A Nursing fac discharge day 	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	reserved. If Yalves are reflected for codes not payable by Medicare, please note that these values have been a fixables as a courtesy to the general public and are not used for Medicare payment. If the budget teattrality reduction from the chiropractic demonstration is not reflected in the RVUs.	codes 88940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment. **Clobed totals for medicarine D.VI's many notes that does to consider a
					~				•																				•													#	. ಜಿ. ದ ಹು	<u> </u>
Mod					7																																					' CPT code	reserved. If values a established The budge	codes 98940, 9894] Medicare payment.

2				Physi- cian	Non- Facility	Facility	-le M		,t3,102			Physi- cian Work	Non- Facility PF	Facility	Maf-	
HCPCS	Mod	Status	Description	RVUs.	RVUs	RVUs ^{2,3}	RVUs ^{2,3,4}	Global	HCPCS Mod	Status	Description	RVUs.23	RVU.	RVUs'	RVUs 2 3.4	Global
99384		z	Prev visit, new, age 12-17	1.53	1.33	0.56	80.0	XXX	99477	٧	Init day hosp neonate care	7.00	ΝΑ	2.44	0.29	XX
99385		Z	Prev visit, new, age 18-39	1.53	1.33	0.56	80:0	XXX	99478	٧	Ic, Ibw inf < 1500 gm subsq	2.75	NA	1.08	0.13	XXX
99386		Z	Prev visit, new, age 40-64	1.88	-46	69.0	0.10	XXX	99479	∢	Ic ibw inf 1500-2500 g subsq	2.50	Ν	66.0	0.12	XXX
99387		Z	Init pm e/m, new pat 65+ yrs	5.06	1.62	0.75	0.11	XXX	99480	A	Ic inf pbw 2501-5000 g subsq	2.40	Z.	0.92	0.12	XXX
99391		Z	Per pm reeval, est pat, inf	1.02	1.05	0.37	0.05	XXX	99499	ပ	Unlisted c&m service	0.00	0.00	0.00	0.00	XXX
99392		z	Prev visit, est, age 1-4	1.19	1,11	0.43	90.0	XXX	99500	,	Home visit, prenatal	0.00	0.00	00:0	0.00	XX
99393		Z,	Prev visit, est, age 5-11	1.19	1.10	0.43	90.0	XXX	99501	-	Home visit, postnatal	00'0	0.00	0.00	0.00	XXX
99394		z	Prev visit, est, age 12-17	1.36	1.17	0.50	0.07	XXX	99502		Home visit, nb care	0.00	0.00	00'0	0.00	XXX
99395		Z	Prev visit, est, age 18-39	1.36	1.17	0.50	0.07	XXX	99503	_	Home visit, resp therapy	00.0	00.00	00'0	0.00	XXX
99396		z	Prev visit, est, age 40-64	1.53	1.23	0.56	80.0	XXX	99504	-	Home visit mech ventilator	0.00	0.00	0.00	000	XXX
79197		z	Per nm reeval est pat 65+ vr	1.71	1.40	0.62	60:0	XXX	99505	7	Home visit, stoma care	0.00	00.0	00.0	0.00	XX
99401		Z	Preventive counseling, indiv	0.48	0.45	0.18	0.03	XXX	99506	_	Home visit, im injection	0.00	0.00	00.0	00:0	XXX
99402		2	Preventive counseling, indiv	860	69'0	0.36	0.05	XXX	99507	,	Home visit, cath maintain	0.00	0.00	0.00	00:00	XXX
99403		; z	Preventive counseling, indiv	46	0.80	0.53	0.08	XXX	99509	_	Home visit day life activity	0.00	0.00	00.0	0.00	XXX
99404		. 2	Preventive counseling indiv	56	86.0	0.71	0.10	XXX	99510	-	Home visit, sing/m/fam couns	0.00	0.00	00.0	0.00	XXX
00406		. ∢	Behav chno smokine 3-10 min	0.24	0.13	0.09	0.01	XXX	99511	_	Home visit, fecal/enema mgmt	00.00	0.00	0.00	00.0	XXX
99400		ς <	Dakon ohno emokimo > 10 min	0.50	27.0	81.0	100	XXX	61566	-	Home visit for hemodialysis	0.00	000	000	0.00	XXX
99407		۲,	Andit duet 15.20 min	0.50	300	0.24	0.03	XXX	00966	. ,	Home visit nos	0.00	0.00	000	000	XXX
99400		2 2	Audiches, 13-30 time	1 30	0.50	0.47	200	XXX	10966		Home inflision/visit 2 hrs	0.00	00:0	000	0.00	XXX
99409		2 2	Audit dast, over 30 titul	91.0	70.0	500	0.0	XXX	3000		Home inflicion each addt he	90.0	000	000	000	XXX
99411		2.7	reventive counseling, group	0.13	07:0	6.0	100	×××	9,002	- g	Temporary tear dust alive	800	800	900	000	XXX
21466		Ζ;	Preventive counsening, group	0.00	67.0	0.0	000	V.V.	44262	a p	Description of the dust plug	0000	00:0	00.0	000	XXX
99420		z. ;	riealth risk assessment test	00.0	0.24	4 S	000	X X	44230	0 0	Cinggeth and decome thank	00.0	9.6	900	000	XXX
99441		Z:	Phone e/m by phys 5-10 mm	0.25	0.12	0.09	0.01	YYY XXX	A4270	9 6	Disposable engoscope sneam	0.00	0.00	9 6	00.0	ξ λ.
99442		Z.	Phone e/m by phys 11-20 mm	0.50	0.21	0,18	0.03	XXX	A4300	n	Cam impi vasc access portai	0.00	90.00	00.0	000	< >>
99443		Z	Phone e/m by phys 21-30 min	0.75	0.31	0.27	0.0	X	A4550	ж 20.	Surgical trays	0.00	0.00	000	000	V X X
99450		z	Basic life disability exam	0.00	0.35	Y.	0.00	XXX	A4890	≃ ;	Repair/maint cont hemo equip	0.00	000	00.0	0.00	XXX
99455		œ	Work related disability exam	0.00	99.0	Y.	0.00	XXX	20008	Κ;	Admin influenza virus vac	0.00	0.00	0.00	0.00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
99456		œ	Disability examination	0.00	0.80	NA	0.00	XXX	C20009	×	Admin pneumococcal vaccine	0.00	0.00	000	0.00	XXX
99460		<	Init nb em per day, hosp	1.17	N.A	4.0	6.05	XXX	00000	×	Admin hepatitis b vaccine	0.00	0.00	00:0	000	XXX
99461		٧	Init nb em per day, non-fac	1.26	1.24	0.46	0.07	XXX	C0101	ď	CA screen; pelvic/breast exam	0.45	0.52	NA.	0.02	XX
99462		A	Sbsq nb em per day, hosp	0.62	NA	0.23	0.03	XXX	G0102	¥	Prostate ca screening; dre	0.17	0.31	0.07	0.01	XX:
99463		٧	Same day nb discharge	1.50	NA	0.70	90:0	XXX	G0104	*	CA screen; flexi sigmoidscope	96'0	2.48	99:0	0.07	000
99464		٧	Attendance at delivery	1.50	N.A	0.51	90.0	XXX		¥	Colorectal scm; hi risk ind	3.69	00.9	1.84	0.26	000
99465		∢	Nb resuscitation	2.93	Ϋ́	1.07	91.0	XXX	G0105 53	Ą	Colorectal scm; hi risk ind	96'0	2.48	99:0	0.05	00
99466		٧	Ped crit care transport	4.79	NA	1.78	0.30	XXX		<	Colon CA screen; barium enema	0.99	4.43	NA	0.05	X
99467		٧	Ped crit care transport add!	2.40	NA	0.94	0.11	222	C0106 TC	¥	Colon CA screen;barium enema	00'0	4.13	K.	0.00	XXX
99468		₹	Neonate crit care, initial	18.46	ΝĀ	7.00	1.15	XXX		¥	Colon CA screen;barium enema	66'0	0.30	0.30	0.05	XX
99469		٧	Neonate crit care, subsq	7.99	Ą.	5.69	0.33	XXX	C0108	×	Diab manage trn per indiv	0.00	0.58	N A	000	XXX
99471		K	Ped critical care, initial	15.98	NA	5.32	29.0	XXX	G0109	٧	Diab manage trn ind/group	0.00	0.30	Υ V	0.00	XXX
99472		₹	Ped critical care, subsq	7.99	NA	2.76	0.37	XXX	G0117	-	Glaucoma seru hgh risk direc	0.45	0.90	N.	0.01	XX
99475		¥	Ped crit care age 2-5, init	11.25	3.45	3.45	99.0	XXX	G0118	{	Glaucoma som hgb risk direc	0.17	0.90	Y.	0.00	×
99476		∢	Ped crit care age 2-5, subsq	6.75	2.07	2.07	0.39	xxx	G0120	∢	Colon ca scm; barium enema	66'0	4.43	NA A	0.05	×××
	, CPT c	odes and	¹ CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	erican Medi	cal Associa	ion. All Rig	hts		CPT	codes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	American Medi	cal Associal	ion. All Rig	bts	
	Reserved	ģ							Reserved.	red.	Reserved.	10000	. that there .	I come bearing	400	
	If valu	ues are re	If values are reflected for codes not payable by Medicare, please note that these values have occu-	e, please note	dicare para	ant and	cen		II Val	shed as a c	It values are reliected for cours not payable by interiorar, picase note that mose values established as a courtesy to the general public and are not used for Medicare payment	are, picase ilou	dicare navm	ent	1122	
	3 The h	industra	established as a countesy to the general phone and are not used for medical payment. The highest perfected in the RVI's for CPT	monstration	is not reflec	led in the R	71/s for CPT		The I	ndget nen	The budget neutrality reduction from the chromactic demonstration is not reflected in the RVUs for CPT	demonstration	is not reflec	ted in the R	Us for CPT	
	codes 9	8940.98	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be 1	reflected in	he files used	for		sapoo	98940,986	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	n will only be	reflected in (he files used	for	
	Medica	re payme	int,						Medic	Medicare payment.	it.					
	4 Globa	d totals fo	Global totals for malpractice RVUs may not sum due to rounding.	rounding.					dolo,	al totals fo	Global totals for malpractice RVUs may not sum due to rounding.	to rounding.				

Reserved.

The lates are reflected for codes not payable by Medicare, please note that these values have been established as a coursey, to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes \$9340, 90841, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

Global totals for malpractice RVUs may not sum due to rounding.

CPT131			,	Physi- cian Work	Non- Facility PE	Facility PE	Mal- Practice		her Led 2				Physi- cian Work	Non- Facility PE	Facility PE	Mai- Practice	
HCPCS	MoM	Startus	Description	RVUs.	RVUs.	RVU	RVUs.	Global	HCPCS	Mod	Staffus	Description	RVUs ^{2,3}	RVUs ^{4.}	RVUs.	RVUs".	Global
07105	2	< -	Colon ca sem; bartum enema	0.00	4.13	Y.	0.00	YYY	0.700		₹ .	VIN I subs tx for change dx	0.45	0.09	0.04	0.02	ξ,
G0120	56	ď	Colon ca sem; barium enema	66'0	0.30	0.30	0.03	XXX	G0271		₹	From MNT 2 or more 30 mms	0.25	0.03	0.02	0.01	XXX
G0121		∢	Colon ca sem not hi rsk ind	3.69	90.9	1.84	0.26	000	G0275		Ψ.	Renal angio, cardiac cath	0.25	V	90'0	0.01	777
G0121	53	4	Colon ca sern not hi rsk ind	96.0	2.48	99:0	0.05	000	G0278		Α	liac art angio, cardíac cath	0.25	ΥZ	80.0	0.01	777
G0122		z	Colon ca scm; barium enema	0.99	6.20	ΥN	0.05	XXX	G0281		Ψ.	Elec stim unattend for press	0.18	0.17	Ϋ́Z	10.0	XXX
G0122	JC	z	Colon ca scm; barium enema	00:0	5.84	ΑN	0.00	XXX	G0282		z	Elect stim wound care not pd	0.00	0.12	Ν	0.00	XXX
G0122	56	Z	Colon ca sem; barium enema	66.0	0.36	0.36	0.05	XXX	G0283		_ _	Elec stim other than wound	0.18	0.17	NA	0.01	XXX
G0124		٨	Screen c/v thin layer by MD	0.42	0.35	0.35	0.02	XXX	G0288		۲ ۲	Recon, CTA for surg plan	0.00	0.85	NA	0.00	XXX
G0127		œ	Trim nail(s)	0.17	0.41	0.04	0.01	000	G0289		ď	Arthro, loose body + chondro	1.48	NA	0.73	0.22	777
G0128		×	CORF skilled nursing service	80.0	0.17	NA	0.00	XXX	G0329		~ ~	Electromagntic tx for ulcers	90.0	0.19	NA	0.00	XXX
G0130		٧	Single energy x-ray study	0.22	0.62	NA	10.0	XXX	G0337		×	Hospice evaluation preelecti	1.42	0.00	0.00	0.11	XX
G0130	Σ	٧	Single energy x-ray study	0.00	0.54	NA VA	0.00	xxx	G0339		Ü	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	XXX
G0130	70	٧	Single energy x-ray study	0.22	60'0	0.09	0.01	XXX	G0340		_ _	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	XXX
G0141		٧	Ser c/v cyto, autosys and md	0.42	0.35	0.35	0.02	XXX	G0341		¥	Percutaneous islet celltrans	86.9	3.03	Ν	0.37	000
G0166		Ą	Extra counterpulse, per tx	0.07	3.38	NA	000	XXX	G0342		¥	aparoscopy islet cell trans	11.92	¥X.	6.76	0.64	060
G0168		4	Wound closure by adhesive	0.45	1.92	0.27	0.03	000	G0343		٧ ۲	aparotomy islet cell transp	19.85	Ϋ́	11.43	1.06	060
G0179		V	MD recentification HHA PT	0.45	0.58	NA	0.02	XXX	G0364			Bone marrow aspirate & biopsy	0.16	0.15	0.07	0.0	277
G0180		٧	MD certification HHA patient	0.67	0.68	ΥN	0.04	XXX	G0365			Vessel mapping hemo access	0,25	5.25	NA	0.03	XXX
G0181		٧	Home health care supervision	1.73	90:	Ϋ́Z	0.08	XXX	G0365	TC	·	Vessel marping hemo access	00'0	5.17	N.A	000	XX
G0182		<	Hospice care supervision	1.73	1.07	NA	80.0	XXX	G0365	56		Vessel mapping hemo access	0.25	80.0	0.08	0.03	XX
60186		Ü	Dstry eye lesn fdr yssl tech	0.00	000	0.00	0.00	AAA	G0372		· •	MD service remired for PMD	0.17	0.07	0.07	0.0	XXX
G0202		*	Screeningmammographydigital	0.70	2.80	N Y	0.05	XXX	G0389		_	Ultrasound exam AAA screen	0.58	2.10	N.	0.0	XXX
G0202	IC	4	Screeningmammographydigital	0.00	2.57	Z.	0.00	XXX	G0389	IC		Ultrasound exam AAA screen	0.00	1.92	N.	000	XXX
G0202	56	4	Screeningmammographydigital	0.70	0.24	0.24	0.05	XXX	G0389	26	_	Itrasound exam AAA screen	0.58	0.18	0.18	0.0	XXX
G0204		¥	Diagnosticmammographydigital	0.87	3.40	N.	0.06	XXX	G0392		\ \	AV fistula or graft arterial	9.48	39.25	3.20	99:0	000
G0204	TC	4	Diagnosticmammographydigital	0.00	3.10	NA	00'0	xxx	G0393			AV fistula or graft venous	6.03	31.10	2.14	0.44	000
G0204	56	Ą	Diagnosticmammographydigital	0.87	0.30	0.30	90.0	XXX	G0396		v V	Alcohol/subs interv 15-30mn	0.65	0.26	0.21	0.03	XXX
G0206		Ą	Diagnosticmaminographydigital	0.70	2.67	NA	0.05	XXX	G0397		۲ ۷	Alcohol/subs interv >30 min	1.30	0.52	0.47	0.07	XXX
G0206	IC	<	Diagnosticmammographydigital	0.00	2.43	NA	0.00	XXX	G0398		C	Home sleep test/type 2 Porta	0.00	0.00	X	0.00	XXX
G0206	56	4	Diagnosticmammographydigital	0.70	0.24	0.24	0.05	XXX	G0398	TC	Ü	Home sleep test/type 2 Porta	0.00	000	NA	0.00	XXX
G0237		4	Therapeutic procd strg endur	0.00	0.21	N.	0.00	XXX	G0398	26	·	Home sleep test/type 2 Porta	0.00	0.00	00.0	000	XXX
G0238		4	Oth resp proc, indiv	0.00	0.22	A'N	0.00	XXX	C0399		O	dome sleep test/type 3 Porta	0.00	0.00	Ν	00:0	XXX
G0239		٧	Oth resp proc. group	0.00	0.27	AN	0.00	XXX	C0399	JC	۔ د	Home sleep test/type 3 Porta	00:0	0.00	ΑA	0.00	XXX
G0245		ď	Initial foot exam pt lops	0.88	0.98	0.40	0.05	XXX	C0336	56	۔ ن	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	XXX
G0246		ď	Followup eval of foot pt lop	0.45	0.62	0.20	0.02	XXX	C0400		် ၁	Home sleep test/type 4 Porta	0.00	0.00	N A	0.00	XXX
G0247		œ	Routine footcare pt w lops	0.50	0.73	0.16	0.03	ZZZ	G0400	TC	၁	Home sleep test/type 4 Porta	0.00	0.00	NA	0.00	XXX
G0248		ď	Demonstrate use home in mon	0.00	2.83	NA	0.00	XXX	G0400	26	ر د	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	XXX
G0249		~	Provide INR test mater/equip	0.00	2.74	NA	00'0	XXX	G0402		۲ V	initial preventive exam	2.30	1.84	NA	90:0	XXX
G0250		~	MD INR test revie inter mgmt	0.18	0.06	NA V	0.01	XXX	G0403		Ψ	3KG for initial prevent exam	0.17	0.33	0.33	0.01	XXX
G0252	56	z	PET imaging initial dx	1.50	0.55	0.55	80.0	XXX	G0404		Y Y	SKG tracing for initial prev	0.00	0.00	NA	0.00	XXX
G0268		4	Removal of impacted wax md	0.61	0.76	0.29	0.02	000	G0405		¥	EKG interpret & report preve	0.17	0.07	0.07	10.0	XXX
G0269		æ	Occlusive device in vein art	0.00	0.00	0.00	0.00	XXX	G0406		V	Telhealth inpt consult 15min	97.0	NA	0.29	0.04	XXX
	CPT C	odes and	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	terican Medi	ical Associa:	tion. All Rig	zhts		-	CPT cod	es and de	CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights	nerican Medi	cal Associati	on. All Righ	ts	
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	if valu	es are re	If values are reflected for codes not payable by Medicare, please note that	e, please not	e that these	these values have been	peen		•	If values	are reflec	If values are reflected for codes not payable by Medicare, please note that these values have been	re, please note	that these v	alues have be	ea	
	The bu	ned as a . idget neu	established as a courtesy to me general public and are not used for Memeare. The budget neutrality reduction from the chiropractic demonstration is not	used for ivit	is not reflected	ted in the R	payment. reflected in the RVUs for CPT		y r.	The budg	i as a cou jet neutra	estabulated as a countesy to the general public and are not used for intedicate payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT.	t used for Me	dicare payme is not reflect	nt. sol in the RV	3s for CPT	
	codes 98	8640, 68	codes 98940, 98941, and 98942. The required reduction will only be reflect	will only be	reflected in t	ed in the files used for	1 for			codes 98940, 9894	10, 9894	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	will only be r	eflected in the	e files used	or.	
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	2	-		-Greener B-							! !	ar and some from the area and and design of the second sec	- Comments				

Physi- Non- clan facility Clan Facility Work PE PE P RVUE* RVUE* 7 RVUE* 7 RV OPPS OPPS OPPS OR RUE	0.18 0.40 0.40	0.37 0.91 0.06	0.42 0.33 0.33	N 950 010	0.20 NA	500	0.37 0.75 0.14	0.00 0.38	0.00 0.00	0.00 0.00 0.00	0.00 0.00	0.00 0.00 NA	0.00 0.00 NA	0.00 0.00 NA	0.00																							CPT codes and descriptions only are copyright 2009 American Medical Association. All Rights		If values are reflected for codes not payable by Medicare, please note that these values have been	catematica as a countesy to the general prioric and are not used not recursare payment. The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT.	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	meureare payment. I Global totals for malgractice RVUs may not sum due to rounding.	
	Pulmonary rehab w exer	Visit for drug moniforing	Colone batterial using	Cardiolomography	Cardiolomography	Cardiologicography	Obtaining screen nan smear	Set up port xray equipment	Brachytherapy Radioelements	Subc inj interferon beta-1a	Collagen skin test	Transport portable x-ray	Transport port x-ray multipl	Transport portable EKG	Hearing service																							d descriptions only are c		effected for codes not pa	utrality reduction from t	3941, and 98942. The re	eut. or maloractice RVUs ma	-
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CPT ¹⁻³	GXX30	M0064	P3001	1000	(2003)	5003	0000	00007	10000	03026	Q3031	R0070	R0075	R0076	V5299																													
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Mat- Practice RVUs ² 3.4 0.07	000	1.56	2.31	2.10	3.21	0.17	10.0	0.10	0.00	0.30	0.55	0.03	0.52	0.62	0.03	0.59	0.02	10.0	0.00	0.00	0.00	0.00	0.00	0.00	000	0.00	000	000	000	000	0.00	0.00	0.02	0.01	See 2010	Rule	See 2010	ehts		peen	VUs for CPT	d for		
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Ron- Facility PE RVUs ^{2,3} NA NA	0.23	NA	Y.	Y ;	Y S	1.13	9.5	21.1	5 2	0.00 41 C	3.76	0.00	3.76	4.24	0.00	4.24	0.22	0.20	0.20	0.15	0.00	0.00	0.00	0.00	0.00	0.00	00:0	3.0	000	0.00	0.00	0.00	0.10	0.03	See 2010	Rule	ŏ	dical Associ		ote that these	neutcare pay on is not refle	e reflected in		
Physican Clan Work RVUs ^{2,3} 1.39	0.00	10.45	15.73	14.65	20.93	3.09	0.00	5.09	900	5.86	10.30	000	10.30	11.61	0.00	11.61	0.54	0.20	0.20	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	900	000	00.0	00:0	0.53	0.25	26c 2010	Rule	See 2010	American Mo		care, please n	not used for it demonstration	on will only b	to rounding.	
Status Description Tebeath inpt-consult 35min A Tebelth inpt consult 35min		_	A Pelvic ring fracture uni/bil					A Set biopsy prostate 1-20 spc		A Sat bionsy prostate 21-40			A Sat biopsy prostate 41-60			A Sat biopsy prostate: >60				 A Low vision rehabilate teache 	I Oncology work-up evaluation	I Oncology tx decision-mgmt	I One surveillance for disease	I One expectant management pt	I One supervision palliative	I Onc visit unspecified NOS	One prac mgmt adheres guide	One pract ment disagree w/mi	One prac ment of ont alterna	One mae ment dif pt comorb	I One prac cond noadd by guide	I One prac guide differs nos	 A Ed svc CKD ind per session 	A Ed svc CKD grp per session		A Intens cardiac rehab w/exerc		nd de	H	² If values are reflected for codes not payable by Medicare, please note that these values have been	established as a courtesy to the general public and are not used for orders are payment. The budget neutrality reduction from the chiropzactic demonstration is not reflected in the RVUs for CPT	codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for	Medicare payment. * Global rotals for maintactice RVI is may not sum due to rounding	
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CPT ¹³ / HCPCS G0407 G0408	G0409	G0412	G0413	G0414	G0415	G0416	50416	50416	1 1 2 2	50417	G0418	G0418	G0418	G0419	G0419	G0419	G9041	G9042	G9043	G9044	C9050	G9051	G9052	G9053	G9054	G9055	G9056	G9057	G0050	09065	19065	G9062	GXX26	GXX27		GXX28	GXX29		,4		~ m	,	V	

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² If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

The budget neutrality reduction from the chropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

* Global totals for malpractice RVUs may not sum due to rounding.

ADDENDUM D: Proposed 2010 Geographic Adjustment Factors (GAFs)

	1000		2010**
Contractor	ty	Locality Name	GAF
00831	Lu	Alaska	1.288*
01102	90	San Mateo, CA	1.204
01102	0.5	Francis	1.201
13202	0.1	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	60	Santa Clara, CA	1.148
12402	0.1	Northern NJ	1.134
31143	0.1	Metropolitan Boston	1.134
01102	0.7	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26		1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
06500	04	Miami, FL	1.114
01192	18	Los Angeles, CA	
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	66	Rest of New Jersey	1.082
		1	
12502	0.1	141	1.075
00953	0.1	MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	0.1	Hawaii/Guam	1.056
00200	03	Fort Lauderdale, FL	1.050
00524	0.1	Rhode Island	1.045
31143	66	husetts	1.041
12302	0.1	Baltimore/Surr. Cntys, MD	1.035
		Poughkpsie/N NYC Suburbs,	
13202	03		1.034
00836	02	Seattle (King Cnty), WA	1.033
01302	0.0		1.016
04402	18	Houston, TX	1.016
12102	10	Delaware	1.014
01102	66	Rest of California*	1.012
01192	66	Rest of California*	1.012
00528	0.1	lΦ	1.010
04402	11	Dallas, TX	1.010
00511	01	ıta, GA	1.005
00952	12	اند	0.989
00973	50	-	0.989
00835	0.1	Portland, OR	0.987
04402	3.1	Austin, TX	0.987

	Locali		2010**
Contractor	ţ	Locality Name	GAF
00520	13	Arkansas	0.891
03402	0.2	South Dakota	0.888
03302	0.1	North Dakota	0.880
00973	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI) +
(0.03865 * mp GPCI).
 *Indicates multiple contractors.
 *AGAF values do not reflect the 1.000 floor on physician work
GPCI established by the MIPPA.
 ***GAF value for Alaska reflects 1.500 floor on physician work
GPCI established by the MIPPA.

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ADDENDUM E: Proposed CY 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Contractor	Locality	Locality Name	GPCI	GPCI	GPCI
00510	00	Alabama	0.982	0.853	0.496
00831	0.1	Alaska	1.500***	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	92	San Francisco, CA	1.059	1.441	0.414
01102	90	San Mateo, CA	1.072	1.433	0.394
01102	60	Santa Clara, CA	1.083	1.294	0.377
01192	1.7	Ventura, CA	1.027	1.265	0.766
01102	66	Rest of California*	1.007	1.058	0.549
01192	66	Rest of California*	1.007	1.058	0.549
04102	0.1	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1,185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	0.1	Delaware	1.011	1.046	0.678
06500	60	Fort Lauderdale, FL	0.989	1.018	2.250
06500	04	Miami, FL	1.000	1.069	3.167
00500	66	Rest of Florida	0.973	0.939	1.724
00511	0.1	Atlanta, GA	1.009	1.014	0.836
00511	66	Rest of Georgia	0.979	0.883	0.829
01202	0.1	Hawaii/Guam	866.0	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	66	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	
09900	00	Kentucky	0.969	0.860	0.652
00528	0.1	New Orleans, LA	0.986	1.044	0.956
00528	66	Rest of Louisiana	0.970	0.878	0.892
31142	03	Southern Maine	0.980	1.025	0.492
31142	66	1	0.962	0.893	0.492
12302	0.1	Baltimore/Surr. Cntys, MD	1,012	1,057	1.086
12302	66	Rest of Maryland	0.994	0.982	0.874
31143	0.1	Metropolitan Boston	1.029	1.291	0.764
31143	66	Rest of Massachusetts	1.007	1.106	0.764
00953	0.1	Detroit, MI	1.036	1.040	1.906

		_			:
Contractor	Locality	Locality Name	GPCI	GPCI	GPCI
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	066.0	0.945	1.188
05392	0.1	Metropolitan St Louis, MO	0.993	0.931	1.075
05392	66	Rest of Missouri*	0.949	0.821	0.997
05302	66	of	0.949	0.821	0.997
03202	10		0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	0.982	1,039	0.462
12402	0.1	Northern NJ	1.057	1.228	1.116
12402	66	Rest of New Jersey	1.042	1.126	1.116
04202	90	New Mexico	0.973	0.890	1.096
13202	0.1	Manhattan, NY	1.064	1.298	1.010
13202	0.2	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	66	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	0.1	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	10	Portland, OR	1.002	1.015	0.472
00835	66	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	66	Rest of Pennsylvania	0.993	0.925	1.081
00973	20	Puerto Rico	0.904	0.694	0.250
00524	0.1	Rhode Island	1.013	1.088	0.996
08800	0.1	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
05440	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	60	Brazoria, TX	1.015	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	966.0	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	66	Rest of Texas	0.968	0.879	1.065
03502	60	Utah	0.977	0.907	1.026
31145	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
0.0973	S.C.C.	Virgin Islands	7997	0 978	1.009

ADDENDUM F: CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

 PR
 MP

 GPCI
 GPCI

 1.085
 0.706

 0.974
 0.693

 0.927
 1.353

 0.921
 0.409

 0.842
 0.889

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
10180	Abilene, TX	0.8413
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.6876
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.9371
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.9423
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.9299
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	•
10740	Albuquerque, NM	0.9953
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8484
	Rapides Parish, LA	

Code Constituent Counties) Index 12060 Atlanta-Sandy Springs-Marietta, GA 1.0307 12060 Barrow County, GA Barrow County, GA Barrow County, GA Carroll County, GA Cherokee County, GA Cherokee County, GA Cherokee County, GA Cherokee County, GA Coob County, GA Coop County, GA Prayette County, GA Prayette County, GA Prayette County, GA Herry County, GA	CBSA	Urban Area	Wage
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Carroll County, GA Cherokee County, GA Clayton County, GA Coweta County, GA Coweta County, GA Dowglas County, GA Dowglas County, GA Fayette County, GA Fayette County, GA Fayette County, GA Fayette County, GA Haralson County, GA Haralson County, GA Heard County, GA Fixe County, GA Matiwether County, GA Newton County, GA Nalantic County, GA Atlantic City-Hammonton, NJ Auburn-Opelika, AL Lee County, AL Augusta-Richmond County, GA McDuffie County, GA Aken County, SC Edgefield County, SC		Butts County, GA	
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CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0199
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9385
***************************************	Blair County, PA	
11100	Amarillo, TX	0.9200
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	1.0055
	Story County, IA	
11260	Anchorage, AK	1.2720
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9584
	Madison County, IN	
11340	Anderson, SC	0.9330
	Anderson County, SC	
11460	Ann Arbor, MI	1.0898
	Washtenaw County, MI	
11500	1	0.8093
	Calhoun County, AL	
11540	Appleton, WI	0.9836
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9605
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1,0051
	ıty, GA	
	Oglethorpe County, GA	
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Code	(Constituent Counties)	Index
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0904
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9299
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9294
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Shelby County, AL	0.9024
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.8086
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8866
14020	. 2	0.9554
14060	Bloomington-Normal, IL McLean County, IL	0.9930
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gen County, ID Owyhee County, ID	0.9835
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2864

	Urban Area	200
Code	(Constituent Counties)	Index
16020	Jackson,	0.9579
	Bollinger County, MO Cape Girardeau County, MO	
16220	Casper, WY	1.0081
	Natrona County, WY	
16300	Cedar Rapids, IA	0.9513
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	
16580	Champaign-Urbana, IL	1.0703
	Champaign County, IL	
	County, I	
	\cup 1	
16620	Charleston, WV	0.8621
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	
16700	Charleston-North Charleston-Summerville, SC	0.9794
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	1.0032
	Anson County, NC	
	Cabarrus County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	0.9923
	Albemarle County, VA	
	Fluvanna County, VA	
	County,	
	Nelson County, VA	
	Charlottesville City, VA	

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
14500	Boulder, CO Boulder County, CO	1.0871
14540	Bowling Green, KY Bdmonson County, KY Warren County, KY	0.8965
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0305
14740	1	1.1388
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT Brownsville-Harlingen, TX Cameron County, TX	1.3539
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9913
15380	a Falls ity, NY Jounty, 1	1.0303
15540	Alamance County, NC Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0702
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1941
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0733
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9313
15980	Cape Coral-Fort Myers, FL Lee County, FL Carson City, NV	0.9610
	172	

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
17420	1	0.8009
	Bradley County, IN Polk County, IN	
17460	Cleveland Elyria-Mentor, OH Cuyahoga County, OH	0.9438
	Geauga County, OH	
	Lake County, OH Lorain County, OH	
	1	
17660	Coeur d'Alene, ID Kootenai County, ID	0.9778
17780	College Station-Bryan, TX	1.0057
	Brazos County, TX Burleson County, TX	
17820	Colorado Springs, CO	1.0399
	-	
	Teller County, CO	
17860	Columbia, MO	0.9124
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9264
	Fairfield County, SC	
	Kershaw County, SC Lewington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.9237
	Russell County, AL	
	Chattahoochee County, GA	
	U	
18020		1.0096
	Bartholomew County, IN	

CBSA	Trban Area	Wage
Code	(Constituent Counties)	Index
16860	TN-GA	0.9351
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9894
_	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1085
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	Will County, IL	
17020	Chico, CA	1.1858
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0037
4	-)))
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	County,	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
17300	Clarksville, TN-KY	0.8449
	Christian County, KY	
	ry Count	
	Stewart County, TN	

		March
Code	(Constituent Counties)	Index
19380	Dayton, OH Greene County, OH Miami County, OH	0.9754
	Montgomery County, OH Preble County, OH	
19460	1	0.8258
	Lawrence County, AL Morgan County, AL	
19500	Decatur, IL	0.8465
	y, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9388
19740	Denver-Aurora-Broomfield, CO	1.1354
	Adams County, CO	
	O	
	v	
	Clear Creek County, CO	
	County,	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	1.0217
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10001	Warren County, 1A	1 0301
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20020	Dothan, AL	0.7842
	Geneva County, AL	
	₩.	
	Houston County, AL	
20100		1.0515
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20220	Dubuque, IA Dubuque County, IA	0.9391

Code 18140 Columbus, OH Pairfield County, OH Frairfield County, OH Norrow County, OH Pickaway County, OH Norrow County, OH Pickaway County, OH Neces County, TX San Patricio County, TX Denton County, WV 19124 Dallas-Plano-Irving, TX Collin County, TX Delta County, TX Delta County, TX Ellis County, TX FRUMT County, TX Delta County, TX FRUMT County, TX FRUMT County, TX Delta County, TX FRUMT COUNTY, T	4000		2000
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Davenport-Moline-Rock Island, Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA			
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		Henry County, IL	
County,			
		County,	

1000	Table of Bank	2000
Code	(Constituent Counties)	Index
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6876
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8654
22140	Farmington, NM San Juan County, NM	0.8353
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9908
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9280
22380	Flagstaff, AZ Coconino County, AZ	1.3209
22420	Flint, MI Genesee County, MI Florence, SC	0.8612
	Darlington County, SC Florence County, SC	
22520		0.8443
22540	du Lac, WI Fond du Lac County	1.0229
22660		1.0774
22 / 44	Lauderdale-Pompano Beach-Deerileld Beach, Broward County, FL	1.000
22900	Fort Smith, AR-OK Crawford County, AR Pranklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8323
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9273

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
20260	Duluth, MN-WI	1.1063
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham-Chapel Hill, NC	1.010.1
	Chatham County, NC	
	Durham County, NC	
	Person County, NC	
20740	Eau Claire, WI	1.0129
	Chippewa County, WI	
	Bau Claire County, WI	
20764	Edison-New Brunswick, NJ	1.1713
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	
20940		0.9282
	Imperial County, CA	
21060	Elizabethtown, KY	0.8882
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	1.0047
	Elkhart County, IN	
21300	Elmira, NY	0.8831
	Chemung County, NY	
21340	TX	0.9044
	El Paso County, TX	
21500		0.8954
	4	
21660	ਨ	1.1684
	Lane County, OR	
21780	Evansville, IN-KY	0.9024
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	ہمر	
	Webster County, KY	
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1768

CBSA	Urban Area	¥age •
Code	(Const	Index
24580	Green Bay, WI	1.0187
	Brown County, WI	
	Kewaunee County, WI	
24660		0.9596
	County,	
	Rockingham County, NC	
24780	Greenville, NC	0.9955
	Greene County, NC	
	Pitt County, NC	
24860	Greenville-Mauldin-Easley, SC	1.0515
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.6876
	Arroyo Municipio, PR	
	Ωŧ	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9300
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.9492
	Washington County, MD	
	,~	
	Morgan County, WV	
25260	Hanford-Corcoran, CA	1.1658
25420		0.9832
	Dauphin County, PA	
25500		0.9556
25540		1.1838
	Hartford County, CT	
	\rightarrow	
	Tolland County, CT	

CBSA	Urban Area (Constituent Counties)	wage Index
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9542
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0058
23420	Fresno, CA Fresno County, CA Gadsden, AL	1.1903
23540	Etowah County, AL Gainesville, FL Alachus County, FL Gilchrist County, FL	0.9507
23580	Gainesville, GA Hall County, GA	0.9660
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9848
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8954
24140	Goldsboro, NC Wayne County, NC	0.9589
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8232
24300		1.0293
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9719
24500	Great Falls, MT Cascade County, MT	0.8845
24540	Greeley, CO Weld County, CO	1.0142

		Maga
Code	(Constituent Counties)	Index
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9992
26900	int I	1.0505
26980	County, 1	1.0110
27100	John Tombkins County, Ni Jackson, Mi Jackson County, Mi	0.9233
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8667
27180		0.9086
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9642
27340	100 1	0.8498
27500	Janesville, WI Rock County, WI	0.9742

ADRD.	III Area	Wage
Code	(Constituent Counties)	Index
25620	Hattiesburg, MS	0.8113
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.9526
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	
25980	Hinesville-Fort Stewart, GA	0,9552
	Liberty County, GA	
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9208
	Ottawa County, MI	
26180		1.2339
	Honolulu County, HI	
26300	Hot Springs, AR	0.9535
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.8338
	Lafourche Parish, LA	
	Terrebonne Parish, LA	
26420	Houston-Sugar Land-Baytown, TX	1.0412
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9632
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9598
	7	
	Madison County, AL	

		40000
Code	(Constituent Counties)	Index
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9214
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8436
28740	Kingston, NY Ulster County, NY	0.9918
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8345
29020	como, IN Howard Tipton	1.0394
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.04v8
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9721
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.9017
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8456
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1092
29420	lū l	1.1189
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8884

Index	0.9222	0.7914	0.8718	0.8176	0.8772	1.0868	1.0772	1.0263	1.1063
Urban Area (Constituent Counties)	 	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	Johnstown, PA Cambria County, PA	Jonesboro, AR Craighead County, AR Poinsett County, AR	Joplin, MO Jasper County, MO Newton County, MO	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	Kankakee-Bradley, IL Kankakee County, IL	Kansas City, MO-KS Franklin County, KS Johnson County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Caldwell County, MO Cass County, MO Clay County, MO Lafayette County, MO Lafayette County, MO Jafayette County, MO Lafayette County, MO Ray County, MO Ray County, MO Ray County, MO Ray County, MO	Kennewick-Pasco-Richland, WA Benton County, WA Paradia County WA
Code	27620	27740	27780	27860	27900	28020	28100	28140	28420

Code	Utban Area (Constituent Counties)	Index
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9522
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8522
31020	yview, WA Cowlitz County, WA	1.1336
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2721
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Shelby County, KY Trimble County, KY	0.9491
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9266
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9023
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0404
31460		0.8426

4000	That are	Wage
Code	(Constituent Countles)	Index
29540	Lancaster, PA	0.9745
29620	Lansing,	1.0218
	Eaton County, MI	
0000	Transfer tower T	0320
00/67		2
29740	Las Cruces, NM	0.9465
29820	Las Vegas-Paradise, NV	1.2835
	Clark County, NV	
29940		0.9085
	Douglas County, KS	
30020		0.8309
	100	
30140		0.8597
	Lebanon County, PA	
30300		1.0134
	Nez Perce County, ID	
	Asotin County, WA	
30340		0.9619
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9412
	Fayette County, KY	
	,>- }	
30620	Lima, OH	0.9913
30700		1.0126
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock-Conway, AR	0.9045
	Faulkner County, AR	
	Grant County, AR	
	ounty, A	
	Saline County, AR	

		Marco
Code	Orban Area (Constituent Counties)	Index
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0748
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Sherce County, MN Sierce County, MN Fierce County, MN	1.1751
33540	Missoula, MT Missoula County, MT Mobile, AL Mobile County, AL	0.9748
33700	Modesto, CA Stanislaus County, CA Monroe, LA Ouachita Parish, LA Union Parish, LA	1.3238
33780	Monroe, MI Monroe County, MI Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.9408
34060	County, mty, WV unty, TN unty, TN	0.8957

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
35380		0.9627
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY Kings County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Rockland County, NY Rockland County, NY Rocklenster County, NY	1.3734
35980	Niles-Benton Harbor, MI Berrien County, MI Norwich-New London, CT New London County, CT	0.9427
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA Ocala, FL	1.7276
36140	Marion County, FL Ocean City, NJ Cape May County, NJ	1.0758
36220	Odessa, TX Ector County, TX Ogden-Clearfield, UT Davis County, UT Weber County, UT	1.0442

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
34580	Mount Vernon-Anacortes, WA Skapit County, WA	1.1068
34620	1 5.1	0.8724
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0401
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9242
34900	Napa, CA Napa County, CA	1.5285
34940	Naples-Marco Island, FL Collier County, FL	1.0231
34980	Nashville-Davidson-MurfreesboroFranklin, TN Cannon County, TN	1.0262
	Cheatham County, TN	
	Hickman County, TN	
	Macon County, TN	
	_	
	Smith County, TN	
	Trousdale County, IN Williamson County. IN	
35004	Nassau-Suffolk, NY	1.3193
	Nassau County, NY Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.2081
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	County,	
35300	New Haven-Milford, CT New Haven County, CT	1.2161
	. 7	

CRCA	Urbar area	Wage
Code	(Constituent Counties)	Index
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8170
	Washington County, OH	
	ounty.	
	V. WT	
	County,	
37700	Pascagoula, MS	0.8930
	George County, MS	
	Jackson County, MS	
37764	Peabody, MA	1.1511
	Essex County, MA	
37860	Pensacola-Ferry Pass-Brent, FL	0.8792
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.9650
	~	
	nty, IL	
	County,	
37964	Philadelphia, PA	1.1356
	Bucks County, PA	
	Chester County, PA	
	unty, PA	
	ounty, PA	
	Philadelphía County, PA	
38060	cottsdal	1.1256
	Maricopa County, AZ	
	Pinal Cou	
38220	Pine Bluff, AR	0.7710
	Cleveland County, AR	
	Lincoln County, AR	
38300		0.9102
	County,	
	Armstrong County, PA	
	_	
	RL.	
	Westmoreland County, PA	
38340		1.1286
	Berkshire County, MA	

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		17.00
Code	(Constituent Counties)	Index
39540	Racine, WI Racine County, WI	0.9924
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0215
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0637
39740	Reading, PA Berks County, PA	0.9808
39820	Redding, CA Shasta County, CA	1.4839
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0891
4 006 0	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cheberland County, VA Dinwiddie County, VA Hanover County, VA Hanover County, VA King and Queen County, VA King william County, VA Louisa County, VA New Kent County, VA Iouisa County, VA Iouisa County, VA New Ect County, VA Iouisa County, VA Hence George County, VA Prince George County, VA Richmond City, VA Richmond City, VA	1.0082
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1884
	1 - Committee of classic decision of decision of the contraction of th	

CBSA	Urban Area	0 000
	(Constituent Counties)	Index
38540 Poc	Pocatello, ID	0.9782
	Bannock County, ID	
	Power County, ID	
38660 Pon	Ponce, PR	0.6876
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860 Por	Portland-South Portland-Biddeford, ME	1.0786
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900 POL	Portland-Vancouver-Beaverton, OR-WA	1.2168
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940 Port	1	1.0479
	Martin County, FL	
	St. Lucie County, FL	
39100 Pou	Poughkeepsie-Newburgh-Middletown, NY	1.1889
na n	Dutchess County, NY	
	Orange County, NY	
39140 Pre	Prescott, AZ	1.0716
39300 Pro	Providence-New Bedford-Fall River, RI-MA	1,1417
····	County,	
	Bristol County, RI	
	Kent County, RI	
	ınty, RI	
********	County,	
	Washington County, RI	
39340 Pro		1.0109
	Juab County, UT	
	Utah County, UT	
39380 Pue	Pueblo, CO	0.9075
	0	
39460 Pun	Punta Gorda, FL	0.9290
	Ober 10440 Court :: 157	

4000		That he says to the says of th	ane W
Code	S	(Constituent Counties)	Index
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	S anty, KS cy, MO anty, MO cy, MO	1.0788
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL Crawford County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Charles County, MO St. Louis County, MO Warren County, MO St. Louis County, MO St. Louis County, MO St. Louis City, MO St. Louis City, MO	aty, IL hty, IL hty, IL nty, IL hty, Mo	0.9637
41420	Salem, OR Marion County, Polk County, OI	zy, or , or	1.1621
41500	Salinas, CA Monterey Co	County, CA	1.6102
41540	Salisbury, MD Somerset Cou Wicomico Cou	County, MD County, MD	0.9647
41620	Salt Lake City, UT Salt Lake Count Summit County, Tooele County,	UT County, UT nty, UT nty, UT	0.9930
41660	San Angelo, TX Irion County, TX Tom Green County,	/, TX punty, TX	0.8380

		Money
Code	(Constituent Counties)	Index
40220	Roanoke, VA	0.9142
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1791
	Dodge County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.9153
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	1.0750
		-
	Winnebago County, IL	
40484	Rockingham County, NH	1.0721
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.9365
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9440
40900		1.4843
	El Dorado County, CA	
	Sacramento county, ca	
0000	YOLO COUNTY, CA	0 0666
40480		
41060	St. Cloud, MIN	1.1761
	Benton County, MN	
	Stearns	
41100	St. George, UT Washington County, UT	0.9780
	, ,	

Code 41980		Tudex
41980	(Constituent Counties)	-
_	San Juan-Caguas-Guaynabo, PR	0.6876
	Aguas Buenas Municipio, PR	*********
	Albonito Municipio, PR	
	Arecibo Municipio, PR	Lamenton.
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Gurabo Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Quebradillas Municipio, PR	
	Grande Municipic	
	San Juan Municipio, PR	
	San Lorenzo Município, PR	
	Toa Alta Municipio, PR	~~~
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	***********
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	

1	Urban Area	Wage
	(Constituent Counties)	Index
San P	San Antonio, TX	0.9365
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
Sar	San Diego-Carlsbad-San Marcos, CA	1.2440
	San Diego County, CA	
Sar	Sandusky, OH	0.9411
	Erie County, OH	
Sar	San Francisco-San Mateo-Redwood City, CA	1.6887
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
Sa	San Germán-Cabo Rojo, PR	0.6876
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
San	1 Jose-Sunnyvale-Santa Clara, CA	1.7348
	San Benito County, CA	
	Santa Clara County, CA	
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4000	TIPLES SACE	Wage
Code	(Constituent Counties)	Index
43620	SD	0.9511
	Mincolf County, SD	
	tha Count	
43780	waka, IN	1.0260
	St. Joseph County, IN	
43900	a. SC	0.9891
9		
44060	Spokane, WA	1.1058
44100	IL	1.0107
44140	Springfield, MA	1.0985
	Hampden County, MA	
	Hampshire County, MA	
44180		0.8524
	Christian County, MO	
	County,	
	Greene County, MO	
44220	HO ,	0.9736
	Clark County, OH	
44300		0.9631
44700	Stockton (A	1.3018
44940	Sumter, SC	0.8631
	Sumter County, SC	
45060	Syracuse, NY	1.0357
	Madison County, NY	
	Onondaga County, NY	
10104	1 []	1 1855
# O T O #	lacoma, wa Pierce County, WA	7

CBSA	Urban Area	Wage
Code	(Constituent Counties)	Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County. CA	1.3288
42044	-Anaheim-Irvine, CA ge County, CA	1.2670
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.3047
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7719
42140	Santa Fe, NM Santa Fe County, NM	1.1324
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6835
42340	Savannah, GA	0.9575
	Bryan County, GA Chatham County, GA Effingham County, GA	
42540	ScrantonWilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8867
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2258
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9912
43100	Sheboygan, WI Sheboygan County, WI	0.9705
43300	Sherman-Denison, TX Grayson County, TX	0.8535
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8877
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9630

Code	Urban Area (Constituent Counties)	Index
46220	1 -	0.9210
	hale county, AL Tuscaloosa County, AL	
46340	Tyler, TX Smith County, TX	0.8802
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8984
46660		0.8412
46700	Vallejo-Fairfield, CA Solano County, CA	1.5813
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8529
47220	Vineland-Willville-Bridgeton, NJ Cumberland County, NJ	1.0807
47260	In the property of the propert	. 0 0 0 0 0 0 4 4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
47300	Visalia-Porterville, CA Tulare County, CA	1.0823

Code	(Constituent Counties)	Index
45220	Tallahassee, FL Gadaden County W.	0.8901
	on County	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9510
	Hillsborough County, FL	
	Fasco county, Fr.	
45460	Terre Haute, IN	0.9486
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8591
	r County,	
	Bowie County, TX	
45780	Toledo, OH	1.0102
	~	
	Wood County, OH	
45820	Topeka, KS	0.9350
	V1	
	Jefferson County, KS	
	υj	
	υş	
	Wabaunsee County, KS	CLF
45240	rencon-bwing, No Mercer County NJ	7/11/7
46060	172	1.0065
	Pima County, AZ	
46140	***************************************	0.9172
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	County,	
	County,	,
	ounty, OF	
	Wagoner County, OK	***************************************

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4000	(Constituent Counties)	Index
2000	יייייייייייייייייייייייייייייייייייייי	1000
48300	4.	1.0291
	Chelan County, WA	
	as County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0460
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.7274
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9498
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Summer County, KS	
48660	Wichita Falls, TX	0.9738
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8341
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.1169
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9515
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0352
	County,	
	city, v	
49180	Winston-Salem, NC	0.9460
	Davie County, NC	
	County,	
	Stokes County, NC	
	Yadkin County, NC	
49340	Worcester, MA	1.1741
49420		1.0534
	Yakima County, WA	

2000	Tables and the second s	War.
Code	(Constituent Counties)	Index
47380	Waco, TX McLennan County, TX	0.8869
47580	Warner Robins, GA Houston County, GA	0.9269
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0394
47894	Mashington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, ND Charles County, ND Prince George's County, ND Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Fauquier County, VA Fauquier County, VA Fauquier County, VA Spotsylvania County, VA Alexandria County, VA Stafford County, VA Marandria City, VA Alexandria City, VA Fairfax City, VA Fairfax City, VA Manassas Park City, VA Manassas City, VA Manassas Park City, VA	1.1521
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.9020
48140	1	0.9996
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7802

ADDENDUM G: CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

0.9070 0.8784 0.8262 0.9290 0.9310 0.7769 0.8651 0.8058 0.9668 0.9464 0.8739 0.7760 1.0513 1.1849 1.0493 1.1767 0.8188 0.9010 0.9084 1.2389 0.8144 1.0244 1.0537 1.2356 0.9230 0.9714 0.8088 0.9104 0.9029 1.2551 0.8912 Wage Nonurban Area North Carolina Massachusetts New Hampshire Connecticut California Mississippi New Mexico New Jersey Louisiana Minnesota Colorado Illinois Michigan Arkansas Delaware Kentucky Maryland Nebraska New York Missouri Montana Arizona Florida Alabama Georgia Indiana Kansas Alaska Hawaii Nevada Idaho Maine Iowa CBSA 19 21 22 25 26 34 10 13 14 16 18 20 23 24 27 28 29 30 31 33

Code 49500 Yauc 49620 York	(Constituent Counties)	•
		Index
	Yauco, PR	0.6876
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
	York-Hanover, PA	0.9847
•	York County, PA	
	Youngstown-Warren-Boardman, OH-PA	0.9114
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
700 Yuba	49700 Yuba City, CA	1.1743
49740 Yuma, AZ	a, AZ	0.9682
	Yuma County, AZ	

CBSA	Nonurban Area	Wage
Code		Index
35	North Dakota	0.8243
36	Ohio	0.8996
3.7	Oklahoma	0.8104
38	Oregon	1.0842
39	Pennsylvania	0.8765
40	Puerto Rico	0.6876
41	Rhode Island¹	
42	South Carolina	0.8863
43	South Dakota	0.8900
44	Tennessee	0.8270
45	Texas	0.8223
46	Utah	0.8856
47	Vermont	1.0338
4 8	Virgin Islands	0.7853
49	Virginia	0.8332
20	Washington	1.0825
51	West Virginia	0.7832
52	Wisconsin	0.9744
53		1.0096
	' All Counties within the State are classified as urban	

[FR Doc. E9–15835 Filed 7–1–09; 11:15 am]

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